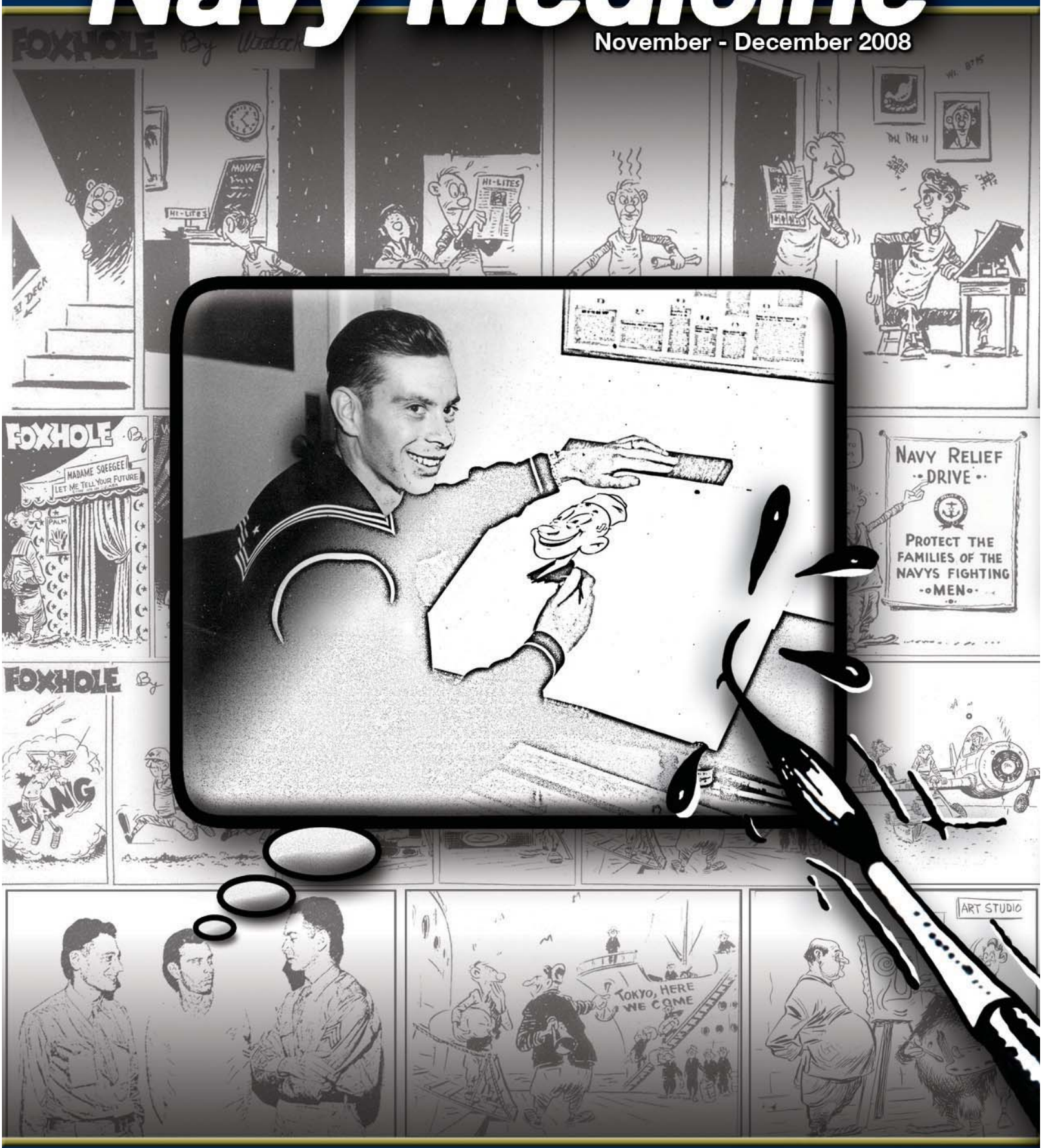
Navy Medicine

November - December 2008



"Woody's World"

NAVY MEDICINE

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We Want Your Opinion

Letters to the Editor are welcome. Let us know what you think about *Navy Medicine*. Please send letters to: Janice Marie Hores, Managing Editor, Bureau of Medicine and Surgery, 2300 E Street, NW, Washington, DC, 20372-5300 or Janice.Hores@med.navy.mil or 19native47@verizon.net

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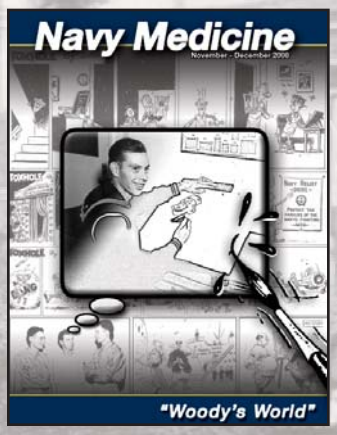

Cover: Woody's World. PhM2c Robert Woodcock did not have a typical service career. During World War II, this hospital corpsman was drawing comic strips to enhance the Navy's morale. His popular weekly comic strip "Foxhole" appeared in several wartime periodicals and served as the Navy's answer to George Baker's "Sad Sack" comic strip. Robert Woodcock in his studio at Naval Hospital Aiea Heights, Territory of Hawaii, and selections from "Foxhole." Courtesy of Robert Woodcock. Story on page 28. Cover design by Shane Stiefel, Navy Medical Support command, Visual Information Directorate, Bethesda, MD.

Online issue of *Navy Medicine* can be found at:
http://navyhistory.med.navy.mil/Publications/NavyMedicineMagazine.html

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Articles and Book Review Submissions

Navy Medicine considers for publication photo essays, artwork, and manuscripts on research, history, unusual experiences, opinion, editorials, and professional matters. Contributions are suitable for consideration by *Navy Medicine* if they represent original material, have cleared internal security review, and received chain of command approval. An author need not be a member of the Navy to submit articles for consideration. For guidelines on submission, please contact: Janice Marie Hores, Managing Editor, Janice.Hores@med.navy.mil or 19native47@verizon.net

Navy Medicine is also looking for book reviews. If you've read a good book dealing with military (Navy) medicine and would like to write a review, the guidelines are:

•Book reviews should be 600 words or less.

•Introductory paragraph must contain: Book name by author. Publisher, city, state. Year published. Number of pages.

•Reviewer ID: sample:

CAPT XYZ is Head of Internal Medicine at Naval Medical Center San Diego.

SAVE A TREE

If you would like to receive your issue electronically via email in PDF format, please contact Janice Marie Hores, Managing Editor, at Janice.Hores@med.navy.mil or 19native47@verizon.net

Admiral's Call

It has been a little over a year since I took office as the Surgeon General. In that time span, I have had frequent opportunities and the distinct pleasure to travel across the United States, to speak to America's youth, and hear what's on their minds. I am awestruck at the amount of individual spirit and ultimate drive to succeed that these young people possess. I'm equally amazed at their innate sense of patriotism.

I speak to these young men and women not only about their future, but the future of this country. These young Americans are the future of our nation. They will occupy the boardrooms and the ward rooms. They will be the future leaders of our military. I try to instill in them the importance of staying focused, staying busy, and leveraging the myriad of opportunities and challenges that lie ahead.

I think it goes without saying that the Navy and this country offer an unlimited and in-depth variety of possibilities, a "cornucopia of opportunity," for all imaginable opinions and diversity of backgrounds to offer their personal insight and wisdom. The culture we live in allows us the freedom to think in terms of possibilities, not limitations.

I have always encouraged all members of Navy medicine, at all levels, to continue their education. I've attempted to get the important message across to all corpsmen, heathcare professionals, and administrative staff that education is a nonstop, never-ending evolution of life. The Navy endorses this principle and, like no other corporate organization, allows its people to pursue an unlimited and vast array of educational opportunities. Whether you make a career of the Navy or serve for just a few years, it is a wonderful launching pad to gain limitless knowledge.

Speaking from personal experience, I can attest to the wealth of opportunity available to those who choose to serve. In 1972, I attended the first Health Professional Scholarship Program (HPSP) which put me through 4 years of medical school at Indiana University. Little did I know back then what that opportunity would lead to—a fulfilling career as a Navy surgeon and my current position as Surgeon General.

The Navy has an extraordinary assortment of educational and career programs offering limitless possibilities. We have a number of programs that will financially help those students who are prepared to go to medical school, and those who seek to enter careers in the health sciences and technology or any other field of their choosing. There are opportunities such as Graduate Medical Education, the Uniformed Services University of the Health Sciences, and the Health Professions Scholarship Program. Students are always welcome to come and visit our hospitals, bases, ships, and schools and are welcome to ask whatever questions they may have.

I am extremely proud to announce that this year, Navy medicine's Medical and Dental Corps both were successful in acquiring new officers. For the first time in several years, the Medical Corps reached its HPSP recruiting goal of 225 while the Dental Corps reached its goal of 57 for HPSP in fiscal year 2008.

Within these successful numbers, there lies much more than meets the eye. What is taking place goes much deeper than numbers, goals, and statistics. Each one of these numbers is attached to a life… to the life of a patriotic individual who is looking to give back and to serve their country. You cannot take the love of freedom out of Americans, and we know all too well that freedom isn't free. The Navy not only provides tremendous professional and educational possibilities, but also the opportunity to develop personally and spiritually and the chance to serve our great nation.

I would also like to take this opportunity to let you know—those of you here at BUMED and those of you who work for Navy medicine across the nation and around the world—that I recognize the service that all of you provide. It is your professionalism, wisdom, and insight that helps me make and implement important policies in Navy medicine. Without your guidance, expertise, and knowledge we would not be able to provide world class, family centered care to those entrusted to us: our sailors and Marines, our veterans and their families. I would like to extend my heartfelt appreciation to all of you for your hard work and service, both to Navy medicine and your country.

For further information on education opportunities and programs please contact:
CDR Kelly Watson, USN
Director of Communication
Special Assistant for Public Affairs
Bureau of Medicine and Surgery
2300 E Street, NW
Room 1217
Washington, DC 20372-5300
202-762-3117
DSN: 285-3117
kelly.watson@med.navy.mil

Farewell

On a crisp March morning nearly 30 years ago, I assumed the editorship of *Navy Medicine*. At the time it was called *U.S. Navy Medicine*. My marching orders from then Surgeon General VADM Willard Arentzen were simple. "Make the magazine something I and the Medical Department can be proud of."

Photo by André Sobocinski

I took his charge seriously, and with the assistance of very able colleagues, Assistant Editor Virginia Novinski and, later, Janice Hores, we succeeded. Even before I arrived on the scene, the publication, begun as the *BuMeD News Letter* in 1943 during World War II, had existed through many lifetimes and several other names—*U.S. Navy Medical News Letter*, *U.S. Navy Medicine, and Navy Medicine*.

The technology was relatively basic in 1979 as were the colors offered—black and white. The linotype process, in which type was cast in hot lead, was then not yet a distant memory, having been recently replaced by photo composition systems. I produced my first issue in April 1979 on one of these. The photo typesetting machine produced galleys that we trimmed to fit the magazine's layout requirements, and then we applied a thin layer of hot wax to provide a basic adhesive.

Computers came next, and desktop publishing—Pagemaker, and now Adobe Creative Suite. Black and white gave way to four-color process, and, slowly but surely, *Navy Medicine* took on a modern look.

The first few months I struggled to learn just what being an editor meant. I was responsible for selecting articles, choosing appropriate photos, approving the design and layout, and aiding my assistant with proofreading. We played with new formats, typefaces, and a crisp new logo for the cover—anything that would give a fresh look. My goal for the magazine was to present material of interest for our readers of all corps—Medical, Dental, Nurse, Medical Service, and Hospital. *Navy Medicine* became a forum for the exchange of ideas and the current practice of military medicine. Some articles were controversial. Were the two new hospital ships commissioned in the late 1980s "white elephants," already obsolescent and too expensive to maintain as the Cold War drew to a close? Or did they have a part to play in providing humanitarian assistance in a world beset by natural and man-made disasters? What would the future hospital ship look like and what would be its role? This debate has played out on the magazine's pages for many years.

As Editor/reporter, I often found myself in environments that would seem a bit exotic to the lay person. I sought to get the story wherever medical personnel did their jobs, offering healthcare to the men and women of the fleet. I hitched rides aboard carriers and even the battleship *Iowa*, where I witnessed a sight never to be seen again—the firing of the 16-inch guns.

I found myself at the Johnson Space Center interviewing CAPT Joe Kerwin, the first American physician to practice medicine in space as an astronaut aboard Skylab. I spent time at the Space Center with another astronaut—Jerry Linenger—before and after his 6-month voyage aboard the Russian Mir space station and shared his experiences as we picnicked on his living room carpet. And I was Jerry's guest at Cape Canaveral on two occasions as the space shuttle blasted him into orbit. I slogged through the mud in a set of cammies at Camp Lejeune with hospital corpsmen as they trained for the Fleet Marine Force.

The adventures have been many and the wonderful folks I've met over the years have made me eager to get out of bed in the morning.

And now 10 Surgeons General and 201 issues later, I leave *Navy Medicine* in very capable hands. Managing Editor, Janice Hores, moves up the masthead as Editor. I retain my title as Historian of the Navy Medical Department with additional responsibilities as Special Assistant to the Surgeon General. I only hope the next 30 years will offer as much fun and challenge as the last 30.

Letter to the Editor

After reading the story by Steven Lomazow, M.D. about VADM Ross T. McIntire in the July-August issue of *Navy Medicine*, I would like to mention another side to McIntire. From late 1942 until some time after Viet Nam was over in 1975, the "sub surgeon" was a legend in the Navy Hospital Corps and submarine service. On 11 September 1942 aboard the USS *Seadragon* (SS-194), then submerged in the South China Sea, PhM1c Wheeler B."Johnny" Lipes performed an appendectomy on Darrell Dean Rector, USNR. The operation was done on a ward room table using bent spoons as retractors and a large tea strainer covered with gauze as a mask. Ether was dripped onto it as anesthesia. The procedure was completed after about 2 ½ hours. Rector returned to duty but did not survive the war. He died 24 October 1944 aboard the USS *Tang* when the submarine fell victim to one of its own errant torpedoes.

All this was done under the command of LCDR W.E. Ferrall, USN, who had ordered Lipes to perform the operation. When the report got back to BUMED, Ross McIntire threatened a court martial for Lipes. After he received word that two other corpsmen assigned to submarines performed appendectomies, McIntire issued orders that no more appendectomies were to be performed by pharmacist's mates and such surgeries would not be tolerated!

During World War II, 26 appendectomies were performed by MDs aboard ships and only 11 survived, while 3 were done by pharmacist's mates and all survived! "Doc" Lipes recalled the situation in a letter dated 21 March 1944: "Surg Gen McIntire, nor any of his staff ever called me in for a debriefing. They didn't want to know anything about such an unspeakable thing as an appendectomy by a layman. BUMED is still looking after the inner circle group and the voracious jealousies inside have not changed."

Here is what others had to say. In a letter from Commander Submarine Squadron Two, the closing sentences read. "PhM1c Lipes is deserving of commendation and suitable recognition. By separate correspondence he is being recommended for immediate promotion to Pharmacist, USN." (Nowadays that would be HMC or Chief (E-7).) From Commander Submarines, Southwest Pacific, VADM Charles Lockwood, Jr., this was said: "The action of W.B. Lipes, PhM1c is considered highly commendable; his skill and willingness to assume responsibility for performing a major operation is outstanding!"

Surg. Gen. McIntire should have been on the next plane for the Pacific with a Navy Cross to pin on Lipes' jumper but instead he wanted him court-martialed and all sub surgery stories erased.

Fortunately, that didn't happen. Instead, when the news hit home, a Pulitzer prize was awarded to George Weller for his story in the *Chicago Daily News* that eventually ended up in the August 1943 *Reader's Digest*. The Hollywood film, "Destination Tokyo" also told the story. As late as the 1950s, a TV series—"The Silent Service"—aired an episode entitled "Operation Seadragon" in which the incident was highlighted.

So we see that McIntire, rather than being "the epitome of the duty and honor of a naval officer," was somewhat lacking in character.

Lipes continued on with his Navy career, eventually becoming a lieutenant commander in the Medical Service Corps. He retired from the Navy in 1962 and became chief executive officer of the 1,000-bed Memphis Hospital, a teaching facility for the University of Tennessee. He was also president of Memorial Medical Center in Corpus Christi, TX.

On 20 February 2005, one of McIntire's successors, former Surgeon General of the Navy VADM Michael Cowan, awarded Lipes a Navy Commendation Medal during a ceremony at USNH Camp Lejeune. During his career, Lipes had served at the Marine Base in the Fleet Marine Force 2nd Marine Division.

Two months after the award, Lipes lost his battle with cancer. This writer knew him during the last 10 years of his life. We communicated through letters and long phone chats. It was an honor and privilege to know him. "Fair winds and following seas, shipmate!"

Charles Stark, Hospital Corps, USN, 1958-1964

Secretary of Defense Robert M. Gates designated November 2008 "Warrior Care Month." Information and resources about Warrior Care can be found at http://www.warriorcare.mil/"

GATES LAUDS IMPROVEMENTS IN WOUNDED WARRIOR CARE

The military has made "some significant steps forward" in caring for wounded warriors, Defense Secretary Robert M. Gates said during a Pentagon Channel interview broadcast 22 October.

Inpatient care provided to wounded warriors always has been world-class, Gates said. "We've never had a problem with that," he said, "and the medical treatment that our soldiers and Marines and airmen and sailors get from the battlefield to these hospitals has no peer anywhere in the world."

The military has made "some significant steps forward" over the past year, Gates said, citing the services' creation of wounded warrior transition organizations.

"I think that the services have really taken a lot of forward steps in terms of improving care, having care managers who make sure that appointments get made and that they're sequenced correctly."

Other improvements are under way with the disability evaluation system (http://www.dtic.mil/whs/directives/corres/pdf/604044p.pdf) that's used to determine how much money injured service members receive after they're discharged, as DOD and Department of Veterans Affairs officials work together toward streamlining that process.

"We have a pilot [disability rating] program where there is just one exam and one rating between us and the VA, but it is just a pilot program," Gates said.

Gates acknowledged that more can be achieved in caring for wounded warriors. "Part of the problem is we make decisions here and we budget money here for things, and it often takes awhile for that to trickle down to individual posts and bases then to the individuals involved," Gates said.

"So, while I think we've accomplished a lot and we are headed absolutely in the right direction, there's no question that we still have further to go, and there's still a gap between where we want to be and where we are."

About $900 million in resources have been earmarked for treatment and research of service members suffering from post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI), Gates stated, and the Defense Department will establish a Center for Excellence at Bethesda, MD, that will specialize in research and development in finding new treatments for PTSD and TBI. "It will be a world-class facility at Bethesda, serving all of the services. There's a lot that we don't know about TBI and PTSD, so we've got a lot of experiments going on around the country."

To help change the military culture to accept that psychological injuries are as devastating as physical wounds, Gates supported the initiative to remove a question on the security clearance form that asked service members whether they ever had received psychological counseling or other kinds of mental health treatment. There's no question, Gates said, that more military people of all ranks are seeking care for mental health issues. "This is another area where we have a strong culture to overcome, where people basically say, 'Suck it up and get on with the job,' and so on, without realizing that people who have PTSD have suffered a wound just like they've been shot and need to be treated." Gates continued.

The Secretary credited Army Chief of Staff GEN George W. Casey Jr., with leading his service in promoting the need for soldiers of all ranks to care for their mental health. Noncommissioned officers of all the services play a key role in monitoring young troops' mental health and encouraging them to seek help, if necessary. Changing military attitudes about mental health issues will take time, Gates acknowledged.

"I think changing Question 21 to where people don't have to worry about losing their security clearance or have their career affected is an important step," Gates said. "But fundamentally, it's a leadership issue in terms of setting an example, of senior officers even acknowledging that they may have had to seek help…and set the example that way."

Gates signs condolence letters for the families of service members who have died in service to their country, and he provides hand-written notes with each one. It's important, he said, for the fallen to be remembered as people and not become statistics.

Shortly after he took office, Gates told his staff he wanted to see photos of each fallen service member, as well as the hometown newspaper obituary, attached to the condolence letters he was to sign. "I want to get to know every one of these people and the sacrifice that they'd made." Though all military members are expected to do their duty, the Secretary said, the sacrifices they make in doing so must not be overlooked. "I think not forgetting the sacrifice that has been made and not letting people become a number is absolutely essential."

With a new administration taking over in January, Gates believes the bonds he has forged with U.S. military members will make it hard for him to leave the Defense Department.

"The opportunity to serve with our troops and to lead them has been the best thing that's ever happened to me."

–Story by Gerry J. Gilmore, American Forces Press Service.

New Service Announced for Wounded Warriors, Families, and Caregivers

DOD announced that the Military OneSource service has established a Wounded Warrior Resource Center telephone number and e-mail address for service members and their families, if they have concerns or other difficulties during their recovery process.

Service members and their family members can now call (800) 342-9647 or e-mail wwrc@militaryonesource.com 24/7 to request support.

Assistance provided by the resource center will not replace the specialized wounded warrior programs established by each of the military services, but it will offer another avenue of assistance for military facilities, healthcare services, and/or benefits information.

"The department is committed to aggressively addressing the needs of our service members and their families," said Secretary of Defense Robert M. Gates.

Specially trained consultants will ensure consistent, quality customer-centric support. The consultants will identify the appropriate "warm hand-off" to either a military service or federal agency with authority to resolve the matter. The resource center consultant will maintain communication with the caller until the issue or concern is resolved.

"The term 'wounded warrior' encompasses the entire population of wounded, ill, and injured service members and veterans," said Principal Deputy Under Secretary of Defense for Personnel and Readiness Michael L. Dominguez.

The Wounded Warrior Resource Center meets the requirements of Section 1616 of the "National Defense Authorization Act Fiscal Year 2008" for a centralized number and ensures wounded families and caregivers have a number to call at any time.

–DOD Press Release.

VA Breaks Ground for New Orlando Medical Center

Fulfilling a commitment to Florida veterans, Secretary of Veterans Affairs Dr. James B. Peake today joined Governor Charlie Crist (R-Fla.), members of the Florida Congressional delegation and local officials to break ground for a $717 million, full-service medical center in Orlando, at a 65-acre site off State Route 417 and Lake Nona Boulevard.

"The groundbreaking for this new VA medical center today is the culmination of a lot of collaborative, hard work. It will result in the best services for our Florida veterans," Secretary Peake said prior to the event. "Support from Florida's governor and congressional delegation has been key and the VA is proud to bring this state-of-the-art facility to Orlando."

When opened in 2012, the one million-plus square-foot facility will have 134 inpatient beds in addition to a 120-bed community living center and 60-bed residential rehabilitation program. The hospital will have two linear accelerators for radiation oncology, eight operating rooms, two cardiac catheterization laboratories, two magnetic resonance imaging (MRI) machines, and several computed tomography (CT) scanners.

An outpatient clinic and a veterans benefits office also are planned at the site.

The facility will be across the street from the University of Central Florida's College of Medicine and Health Sciences campus, along with the Burnham Institute of Research and the Nemours Children's Hospital, creating a "medical city" in southeast Orlando.

People wishing to receive e-mail from VA with the latest news releases and updated fact sheets can subscribe to the VA Office of Public Affairs Distribution List http://www1.va.gov/opa/pressrel/opa_ListServ.asp

Naval Hospital Gets Clean Bill of Health

Naval Hospital Camp Lejeune, NC, has been fully re-accredited by the Joint Commission on Accreditation of Health Care Organizations after a 5-day review of practices and procedures. The 3-year accreditation validates that the hospital meets the national standards of care.

In late August, the hospital was visited by an 18-member team comprised of inspectors from Joint Commission and the Navy Medical Inspector General. The commanding officer received a short 5-day notice that they would be arriving.

"We did well and I am pleased that the surveyors chose our hospital to visit at this time. We know that we always have room for improvement and they pointed out some areas that we can improve on. Our hospital has a very dedicated and hard working staff who work together as a team to meet the mission. I am pleased with their overall efforts," said CAPT Gerard Cox, commanding officer. Cox had been onboard for a little over a week when the survey teams arrived.

During the combined visit, the surveyors did not focus solely only on the hospital main building, but visited the six hospital branch clinics. They evaluated medical and military unique programs that included the quality of healthcare, training programs, and staff education.

"We are committed to providing superb family centered care to thousands of Marines and sailors of the II MEF, retirees and their family members living in the Camp Lejeune

area. The simultaneous visit by the Joint Commission and the Medical Inspector General means that our programs were carefully evaluated and that our hospital is safe," said Cox.

–Story by Raymond Applewhite, Public Affairs Office.

Project FOCUS Helps Families Build Resilience to Cope With Wartime Stress

The FOCUS Project (Families Over Coming Under Stress) is a resiliency building program designed for military families and children facing the multiple challenges of combat operational stress during wartime.

FOCUS is founded on leading evidenced based family intervention models for at risk families which have demonstrated positive emotional, behavioral, and adaptive outcomes for families over time.

In the U.S. today, about 1.2 million children have an active duty military parent. In the Navy and Marine Corps, about 40 percent of service members have at least one dependent child under the age of 18. Throughout all the branches of the military, children are affected by a recent or current deployment of a parent to the combat zones of Iraq or Afghanistan.

Wartime deployment takes a toll on both the service member and family members on the homefront, with multiple deployments often causing additional stress. The growing awareness of the significant challenges of these deployments on military family life and child and family well-being has prompted a new initiative from the Bureau of Medicine and Surgery (BUMED). Addressing concerns related to parental combat operational stress injuries and combat related physical injuries, state-of-the-art family resiliency services are being provided to Navy and Marine Corps children and families through FOCUS which began in the Spring of 2008.

As a service project funded through BUMED, FOCUS is providing services for families based at the following Marine, Seabee, and Naval Special Warfare installations:

MCB Camp Pendleton, CA
MCB Camp Lejeune, NC
MCB Twenty-Nine Palms, CA
MCB HI
MCB Okinawa, Japan
Naval CBC Gulfport, MS
Naval CBC Port Hueneme, CA
NAB Coronado Island, CA
NAB Little Creek, VA

Headquartered at UCLA, FOCUS is working closely with BUMED and the Combat Operational Stress Control (COSC) team at USMC headquarters in Quantico, VA.

Working with the existing teams of dedicated military family services personnel, FOCUS staff assist families to better understand how combat operational stress affects them and their service family member. Also how to manage it, and how to strengthen themselves and their children in readiness for tomorrow.

At each location, the FOCUS team consists of three to four staff members. These team members are doctrinally prepared mental health professionals. They provide family training techniques to highlight areas of strength and resilience in the family, as well as promote family growth to help address current challenges.

These skills are achieved through presentations:

•program overview containing education information, and broad outreach to the general population.

•individual direct outreach, containing education, networking, referral, and resource development to medical providers, military leaders, and family representatives.

•group direct outreach, containing briefs, program overview, and education to medical providers, military leaders, and family groups.

•core skill-building interactive groups, containing coping skills (emotional regulation, communication, goal setting, problem solving, and managing combat reminders) for individuals, school aged children, teen groups, family, and service member.

•family multi-session resiliency training, containing education, developmental guidance, combat operational stress control, parenting/family life, resiliency skills for children and parents, a family narrative, communication, perspective taking and shared meaning.

•individual and organization consultation, containing education (e.g., school counselor in-service), expert guidance on family and/or child focused information on deployment and/or combat operational stress related issues.

•trauma informed consultation, containing community loss and grief, provider education, and individual child/family needs.

Over 7,000 attendees and participants have been recorded at all FOCUS services to date and over 3,600 family members have received FOCUS direct services.

–Story by Kirsten Woodward, Family Programs Coordinator, Bureau of Medicine and Surgery.

NMCSD Puts Finishing Touches on Facility Beautification Project

Naval Medical Center San Diego (NMCSD) recently finished a 4-month, $3.2 million facility beautification project to improve conditions and quality of care for service members and their families. This was the first major redesign to the hospital's various wards since they initially opened in 1988.

"The facility is about 20 years old and it was starting to show its age," said CDR James C. Gay, Directorate of Nursing Services medical administrative officer. "We wanted to do everything we could to make the facility look modern and welcoming."

A newly-renovated fetal assessment room. Photo by MC2 Alexander Ameen, USN

RADM Christine Hunter, NMCSD commanding officer, visited a local medical facility that was remodeling to better suit the needs of its patients. She realized that making those kinds of changes at NMCSD was something that needed to happen sooner rather than later, Gay said.

"In prior decades, people wanted their hospitals to be white, look sterile. The facilities we built reflected that," said Gay. "Nowadays, that is not what our patients expect from us at all. They want a homier environment and they want things to feel more familiar to them. The inpatient wards just didn't reflect that in their previous state."

The first step in making necessary upgrades was talking to the people who knew it the best, Gay said.

"We talked to both the patients and the staff and asked them what they wanted. One of their primary comments was that everything looked the same, so people never knew where they were. Another comment was that the actual patient rooms were often depressing because they were dark. Along those lines, furniture had been acquired piecemeal over 20 years and often did not match. We wanted to make the new design look more inviting and less clinical," said Gay.

A designer was hired as a key component of the project. A design team headed by CDR Martha Cutshall, NC, and comprised of both senior and junior nurses made recommendations for color, fabric, art, and style, said Gay. This was presented to Naval Hospital leadership for approval. These efforts resulted in a product that is both aesthetically pleasing and functional in a clinical environment. Gay noted that the resulting design has become a permanent template to guide all future purchases.

Being a hospital, factors such as infection control and cleanliness were vital in choosing new furniture and surfaces.

ENS Sarah Jagger, NMCSD staff nurse, said the improvements have made a significant difference around the facility.

"The patient rooms feel more comfortable now," she said. "We've increased the amount of space patients have to store their belongings, and that helps out with family members who might be spending hours at the bedside too."

The improvements at NMCSD also created a more comfortable accommodation for the staff.

"We upgraded the locker room areas, which allows our staff the opportunity to commute here in civilian clothes and change into their uniforms on site," said Gay. "We also improved the common eating areas."

In addition, the artwork on the walls was upgraded. "People wanted the décor to reflect the fact that we're a military hospital," he said. "We're treating service members now who are coming home from difficult situations, and we wanted to represent their circumstances respectfully. We turned to military photographers and got some great pictures from all branches to better display who we are and what we represent."

Gay and Jagger agreed that the changes were positive for both the patients and staff and were well worth the money the project cost.

–Story by MC2 Alexander Ameen, USN.

Hi-Def Images and Quicker Scans Revolutionize Diagnoses

It's just gotten a lot easier to diagnose patients at Naval Medical Center Portsmouth using non-invasive techniques.

Two recent upgrades in the Radiology department translate into quicker testing and more accurate diagnoses as well as more patients seen in a shorter period of time. The technology is able to show one's insides with much greater detail, making problems easier to identify.

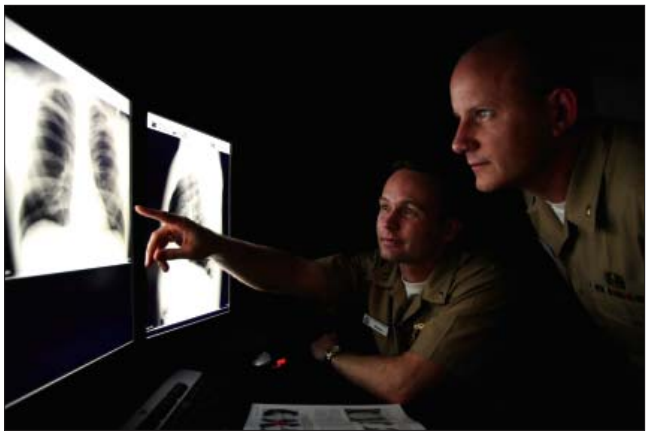
CDR Ted St. John is head of Radiology. He calls the upgrades, "diagnosis through images that will effectively do away with exploratory surgery."

On the MRI side of the department, hi-def images are now the rule, and Portsmouth is the only Navy medical facility to offer them. The upgrade to the MRI scanner provides high-definition technology to reconstruct images very rapidly, resulting in near instantaneous images of one's insides. The orthopedics department is excited that the MRI can obtain cartigrams, a new color-mapping process used for cartilage evaluation.

MRIs use radio waves and a strong magnetic field to produce detailed cross-section images of the body. The CT scanner renders a 3D image using X-rays.

"Early next year, we'll be getting a higher-powered magnet for the MRI," said St. John. "That will allow us to get patients through faster, and not have to refer as many to the TRICARE network, therefore saving the government money."

The new 64-slice CT scanner is more than twice as fast as radiology's old 4-slice CT scanner. While the old unit actually produced images in slices, the new scanner actually acquires volumes, capturing images on 64 channels simultaneously



LTs Mark Bomia (left) and Daniel Sutton look at X-rays on the Portsmouth hospital's new LCD screens in radiology. Photo by MC2 William Heimbuch

in high-resolution detail. It can capture high quality images of a beating heart in only five beats or an entire organ in 1 second, and it can perform a whole body trauma scan in 10 seconds.

"It reduced the amount of radiation the patient receives, and a scan that used to take up to a minute can now be done in 10 seconds," said St. John.

It helps rule in (or rule out) three of the most life-threatening critical conditions in chest pain in one single scan: aortic dissection, pulmonary embolism, and coronary artery disease. For patients who've had a stroke, the CT scanner can rapidly examine the blood vessels in the brain so the doctor can determine the best course of treatments.

The multi-million dollar upgrades aren't cheap, but they are a quantum leap in the quality of healthcare NMCP provides its patients.

–Story by Deborah Kallgren, NMCP, Public Affairs.

Navy Medicine IM/IT Command Celebrates Arrival in San Antonio

The Navy Medicine Information Systems Support Activity (NAVMISSA) held a ribbon cutting ceremony 21 October to celebrate the command's arrival in San Antonio.

Navy Medicine's IM/IT center was reorganized from the Naval Medical Information Management Center at Bethesda to NAVMISSA on 1 September and continues steps to become fully operational in San Antonio.

RDML Richard Vinci, Commander, Navy Medicine Support Command (NMSC), was the guest speaker and spoke about the NAVMISSA team accomplishments and future changes. NMSC is NAVMISSA's parent command.

"CAPT Ortiz (NAVMISSA commanding officer) has led a talented, hardworking team of what I affectionately call 'electronic brainiacs,'" Vinci said. "The team is aligning NAVMISSA with the DOD Military Health System (MHS) and TMA (TRICARE Management Activity). Their hard work will ultimately pay off with superior information systems products and services across Navy medicine."

Providing superior information systems products and services to Navy medicine is NAVMISSA's mission. NAVMISSA also protects Navy medicine networks through an effective Information Assurance program that ensures customer privacy, Ortiz said.

NAVMISSA is projected to employ 149 people when the command is fully operational April 2009 and the Bethesda detachment is closed. The majority of the staff will be hired from the San Antonio area.

Ortiz said there are several benefits to the San Antonio relocation. Relocating to San Antonio places NAVMISSA geographically close to its Army and Air Force service partners but still allows it to remain a separate command. Economic benefits include the ability to attract and retain the right work force while realizing significant cost of living reductions when compared to the metropolitan DC area.

There will also be benefits to Navy medicine, said Patricia Craddock, the NMSC M-5 deputy chief of staff who is responsible for NAVMISSA.

"As NAVMISSA transitions to San Antonio, they will rebuild the organization using a new organization map that will be more agile and capable of responding to the customer's needs," she said."The new organizational structure will offer stronger program management, which will match the requirements of a system based on the phase of its life cycle, development and deployment, sustainment, or retirement, for instance."

–Story by Larry Coffey, NMSC Public Affairs.

From left to right: CAPT Tina Ortiz, RDML Richard Vinci, and RDML Jerry R. Kelley, Deputy Commander, Total Force Integration, cut the ceremonial ribbon. Photo courtesy of Larry Coffey

Caring for the Fallen

Naval Hospital Bremerton's Chief Petty Officer Selectees showed respect for those who made the ultimate sacrifice for their country by helping to renovate the hallowed ground of Ivy Green Cemetery of Bremerton, WA.

There are approximately 6,000 people laid to rest at the cemetery, of which several thousand are military veterans. Ivy Green is also the resting site for Navy Quartermaster John H. Nibbe, one of the earliest recipients of the Medal of Honor. He was cited for his courage under fire while on the gunboat USS *Peterel* during Civil War action on the Yazoo River in 1864.

"It's an honor to be able to come here and help out," said HMC Mark Coulombe, one of the NHB volunteers undertaking the community relations project. "Just being here is symbolic and is a mark of respect to our roots."

The CPO-Selectees and their CPO sponsors handled ground-keeping chores and replaced railroad ties that served as steps to the Navy plot. They chipped, sanded, and painted worn portions on the replica of the Tomb of the Unknown Soldier and completely spruced up Nibbe's grave marker and site.

According to Don Hock, City of Bremerton Parks and Recreation Department cemetery grounds keeper and manager, the original cemetery opened in 1898 and expanded in 1902. There are veterans from every branch of the service from as far back as the Civil War, Spanish-American War, both World Wars, the Korean War, and Vietnam. "We don't have any yet from Iraq or Afghanistan, knock on wood," Hock said.

"There is a lot of history here," said Gunner's Mate Chief-Select Kevin Wyant, engaged in cleaning up the Navy plot. "Being here lets us give back to our community."

HMC Tim Severtson whisks away debris as HMC-Select Mark Coulombe applies some TLC preventive maintenance on the gravesite of Navy Quartermaster John H. Nibbe. Photo by Douglas H. Stutz

The Navy plot is the largest in the cemetery and is the final resting place for 61 crew members killed in action on USS *Saratoga* (CV-30), on 21 February 1945, off Iwo Jima. "*Saratoga* was brought back to the Bremerton shipyard for necessary repairs," related Hock. "There were remains on board that couldn't be identified after the ship was bombed by attacking Japanese airplanes, so the best way to honor them all was with a group memorial."

"The importance of this site in our own backyard simply can't be ignored," commented HMC Severtson. "It really just takes us a little planning and foresight to carry out a project like this and ensure that those who came before us are properly cared for. I'd like to do this on a regular basis. It's the least we can do to honor them."

–Story by Douglas H. Stutz, Naval Hospital Bremerton Public Affairs.

Navy Tradition Extended to Babies

DING DING ... DING DING ... "New babies arriving!"

That's the announcement Naval Medical Center Portsmouth (NMCP) makes every day at noon over the hospital's public address system. Just as a ship's bell is tolled for the piping aboard of dignitaries, so now the hospital's bell is tolled for the "arrival" of service members' babies born at NMCP.

"The bell is a long standing naval tradition. It's really quite old," said CAPT Craig Bonnema, NMCP's Deputy Commander. "It's our desire to celebrate new babies and to welcome them in a naval fashion."

The service began in September. NMCP has the distinction of being the nation's first permanent naval hospital. Nicknamed the "First and Finest," it has proudly served the healthcare and medical needs of the nation's military continuously since 1830.

–Story by Deborah Kallgren, NMCP Public Affairs.

Trevor David Wert and mom. Photo by MC2 Willaim Heimbuch

NHCS Classroom Named for KIA Corpsman

Classroom number 213 at Naval Hospital Corps School now bears the name of HM2 Anthony Carbullido, who was killed by an improvised explosive device (IED) on 8 August while serving as a combat medic embedded with the Army in Herat, Afghanistan. "Each instructional home room at Naval Hospital Corps School is named after gallant corpsman who valiantly gave their lives for the service of their country," said CDR Roger Bouma, CHC. "Named classrooms and scholarships are two vivid important means to carry the memory of a hero into the future."

A $30,000 4-year scholarship is being donated to the late petty officer's daughter Lexie by the Marine Corps Scholarship Foundation. "This is especially generous of the foundation since Anthony was actually serving with the Army when he gave his life in service of his country," said Bouma.

The Marine Corps Scholarship Foundation awards scholarships to every child of a Marine or Navy corpsman serving with the Marines, whose parent is killed in the global war on terror.

Their primary mission is to provide financial assistance to deserving sons and daughters of Marines and of former Marines. "Additionally, the foundation recognizes the sacrifices borne by the families of their beloved 'docs,' and it is in tribute to these corpsmen that these scholarships are provided," noted Alan Hammer, foundation secretary.

"Since 1962, the foundation has awarded more than 22,500 scholarships and bonds totaling more than $39.2 million, including $4.55 million to 1,394 scholarship recipients in 2008."More information about these scholarships can be found at www.mcsf.org.

Having classrooms named in honor of heroes gives each student a role model from history to guide them through the 14-week school curriculum. Along with the close guidance of their instructors, corps school students with artistic talent also traditionally paint a mural in honor of their classroom's historic mentor. The mural representing Carbullido is currently in the design phase.

Born on 25 August 1982 in Agat, Guam, Carbullido enlisted in the Navy in 2000. Although he enlisted to be a corpsman, his goal was to be a physician. After graduating boot camp in 2001, Carbullido enrolled at Naval Hospital Corps School where he graduated in August 2001. He was assigned to Naval Medical Center in San Diego and then to Fleet Medical Service School (FMSS), Camp Pendleton, CA. After a short time with Marine Forces Pacific, he was assigned to First Marine Logistics Group.

Carbullido served two tours as a combat medic with Marine Corps units and then returned to NHCS in November 2005 as an instructor. He then volunteered for an individual augmentee assignment as a combat medic with the Army. As a direct result of his heroic actions, Carbullido was awarded the Bronze Star with Valor, Purple Heart, and Marine Corps Commendation Medal.

–Naval Hospital Corps School Newsletter, Great Lakes, IL.

2nd Medical Battalion Shock Trauma Platoon Display

On 17-18 September approximately 45 members of 2nd Medical Battalion from Camp Lejeune, NC, manned a Shock Trauma Platoon (STP) display at Naval Medical Center Portsmouth.

The Battalion personnel gave a demonstration, provided information on STP's mission, and discussed the training pipeline for staff members and visitors.

Members from NMCP's Simulation Center and the Emergency Department participated and talked about their roles in forward deployed Navy medicine missions and their training pipeline.

–Story by Deborah Kallgren, NMCP Public Affairs.

LT Jason Renschler gives examples of what it would be like in the FRSS operating room tent.
Photo by MC2 William Heimbuch, USN

Pacific Partnership 2008

Uman, Federated States of Micronesia. LT Sara Pope listens to a child's heart. Photo by MC2 (SW) Mark Logico, USN

Timor-Leste. Dr. Arie Zakaria, from the Indonesian Navy (center) works alongside CDR William E. Todd, MC, (left), a pediatric orthopedic surgeon on a femoral malunion plating. The operation consists of straightening a broken femur and keeping it straight by securing it with a metal plate. Photo by MC1(SW) A. Nick De La Cruz, USN

Military Sealift Command hospital ship, USNS *Mercy* (T-AH 19), returned to San Diego 25 September after completing Pacific Partnership 2008, a 4-month humanitarian/civic assistance (HCA) and theater security cooperation mission, conducted with countries from the Western Pacific and Southeast Asia.

Throughout the Pacific Partnership 2008 mission, *Mercy* served as an enabling platform for military and nongovernmental organizations (NGOs) to coordinate and carry out HCA efforts in the Republic of the Philippines, Vietnam, the Federated States of Micronesia, Timor-Leste, and Papua New Guinea. As part of the Maritime Strategy, the relationships built and sustained with multinational partners in the Asia-Pacific region through exercises and professional and military exchanges help in humanitarian efforts and preserve peace and stability in the region.

During this year's mission, more than 90,000 patients were treated by the medical teams in various locations throughout the Western Pacific, including more than 1,300 surgery patients and more than 14,000 dental patients, who received dental care and treatment.

Community outreach and improvement included 26 engineering projects ranging from the construction of a wastewater treatment facility in the Philippines to the construction of a community center in Papua New Guinea. Many NGOs participated throughout the Pacific Partnership 2008 mis-

Maguindanao, Philippines. HM2 Daniel Raykiewicz registers new patients at the elementary school in the district of Matanog, Maguindanao, Philippines on the first day of Pacific Partnership 2008. Photo by MC2(SW) Mark Logico, USN

Pohnpei, Federated States of Micronesia. Indian Navy surgeon CDR Ranjeet Thergaonkar listens to a patient's heart at Sapwalap Elementary School in Pohnpei. Thergaonkar, from Nagpur, India, joined the *Mercy*'s crew in May. Photo by MC1(SW) A. Nick De La Cruz, USN

Aboard *Mercy*, Republic of the Philippines. Three-year-old Jose Angelo Dacuycuy eats his first meal after having surgery to correct his Hirschsprung's disease. Photo by MC3(SW) Joshua Martin USN

sion, including the Aloha Medical Mission, Project Hope, Operation Smile, The University of California San Diego Pre-Dental Society, International Relief Teams, and others already operating, and working solely within, the countries *Mercy* visited.

Medical and engineering professionals from the partner and host nations of Australia, Canada, Chile, India, Indonesia, Japan, New Zealand, Republic of Korea, Portugal, Singapore, Republic of the Philippines, Vietnam, Timor-Leste, Papua New Guinea, and the Federated States of Micronesia served on the Pacific Partnership team.

Mercy's crew included personnel from public health/preventive medicine, U.S. Navy, U.S. Army and U.S. Air Force medicine, U.S. Public Health Service, the U.S. Navy's Military Sealift Command, and the U.S. Navy Seabees.

CAPT W. A. Kearns III, from Destroyer Squadron 31, served as the Pacific Partnership mission commander. CAPT Robert T. Wiley, a civil service mariner with MSC was the ship's master, and the commanding officer of Mercy's Military Treatment Facility was CAPT James P. Rice.

–Story from U.S. 3rd Fleet Public Affairs.

BACKGROUND: USNS *Mercy* (T-AH 19) approaches the pier at Naval Base San Diego concluding a 4-month Pacific Partnership 2008 deployment to Southeast Asia. Photo by MC3 Jon Husman, USN

Egyptian Hospital in Afghanistan Provides Care, Changes Attitudes

For some, it's the opportunity to see for the first time in 10 years. For others, it could provide an artificial limb that will allow them to walk again after losing a leg to a land mine.

Regardless of what they come for, and where they come from, they all come for the same primary reason—because there's nowhere else to go.

There are other reasons Afghans come to the Egyptian Field Hospital at Bagram, Afghanistan. It's free, for one. But there's something else about it that hits home with the people who come looking for care. COL Ahmed Ashry has a very good idea of what that something else is, as well as the practical side of benefits he and his co-workers' services provide.

He's the chief of doctors at the field hospital and holds a doctor of philosophy degree in ophthalmology, a branch of medicine that deals with visual pathways. When he's not coming up with new ways to make the hospital better, he's usually busy in surgery fixing someone's eyes. Ashry, like many of his co-workers, comes from Cairo, Egypt. He's been deployed here since early June, along with much of his staff.

Since he came to Bagram, he's been on a complex mission that started with some practical steps, and then evolved into something a little more extreme. "When I came here, I told the commander I wanted to change everything," Ashry said.

The first thing the colonel did was to develop a system for tracking patients, based on the system used at the American hospital on Bagram Airfield. The second was expanding the hospital from 20 inpatient beds to 30 and building a new intensive care unit and operating room.

The colonel said the opening of the ICU and operating room was good timing, because the second day after they opened, the hospital saw three trauma patients. The most extreme case was a mine explosion victim who had lost both legs above the knee.

The doctor said by the time they received the patient he had lost so much blood he wasn't bleeding any more and wasn't expected to live. His blood pressure was 40/20; normal human blood pressure is about 120/80. He lived, though, thanks to the new operating room and ICU and a large blood supply from the American hospital.

As if the improvements weren't enough, the colonel's next idea was a little more radical. Instead of seeing only the 100 or so patients he and his staff were seeing every day, the colonel decided to attempt to see every patient who came for one week. "Why should we take only 100 patients?" the colonel said. "We should take all the patients. So I did an experiment; one week, we took all of the patients."

On the first day of the new policy, the colonel said they saw 520 patients. At first, the American hospital did not believe they could have seen that many patients in one day. Then some of their leadership came and saw the vast numbers who showed up the following morning.

Afghans wait in line outside of the Egyptian Field Hospital. Photo by Senior Airman George Cloutier, USAF

The colonel said he can sleep easier now knowing that he's not turning anyone away. After all, the colonel said, if he doesn't do it, nobody's going to. "You have to do it—you have to do everything here," he said. "You can't tell the patient, 'Sorry, I can't do it.' I can sleep at night with a good conscience, because I don't say 'no' to the patients."

Lately, the colonel has turned his attention to another problem. It's not a physical disease, but something that runs deep into the minds of the people who come to the Egyptian hospital—cultural and religious considerations. The colonel said one of the things that gives the Egyptians an advantage working in Afghanistan is that they share a similar culture and religion with the Afghan people. This makes it easier for people to come to them for medical help, where they may not come to Americans.

The colonel said this stigma is due to a misunderstanding the Afghan people have with Americans and the other forces who have been here in the past. "Some people don't understand the Americans have come to give freedom to them," the colonel said. "When I speak to them I ask, 'OK, if you are correct, why did the Americans set up a hospital for you? We came here with the permission of the Americans, and they gave us equipment and drugs.'"

To clear up this misunderstanding, the colonel decided to try a new idea. He asked for volunteers from the American hospital to come once a week, not to see patients, but just to do simple things such as handing out food and water. It may not seem like much, however, the colonel said that before long he began seeing a change in the attitude of the Afghan patients toward the Americans.

"Day-by-day, the Afghans begin to think, these are the Americans," the colonel said. "Every day, they come here to give me food and water, they give me help, and they speak to me." The colonel said since Americans started coming to the Egyptian hospital, patients have begun to specifically ask to be seen by American caregivers. In general, the patients now are willing to receive treatment from Americans, where before they would refuse. The colonel and many of his staff still have 4 more months

on their rotation. In the following months, he has a lot of ideas to further improve the hospital, such as new endoscopy department, dialysis machine, and an incubator for newborns.

The colonel said one idea that will be around for much longer than any of these and have a much more far-reaching impact is a new mentoring program the hospital started earlier. It gives Afghan doctors a chance to practice their skills and learn from Egyptian and American doctors. "This hospital will not stay here forever—not the American or the Egyptian—and one day it will belong to the Afghans," the colonel said. "I suggest to every Afghan doctor here, 'Please come, don't waste a moment. Do everything and learn everything, because one day we will leave and this will be an Afghan hospital.'"

–Story by Air Force Senior Airman George Cloutier, American Forces Network Afghanistan.

AMSCON Leadership Awards Announced

The Association of the Medical Service Corps of the Navy (AMSCON) is the organization formed to conduct charitable, scientific, and educational programs for its members. It acts as an advocate on issues and matters pertinent to the Medical Service Corps (MSC).

AMSCON provides several awards to outstanding MSC officers. The most prestigious, the Clarence J. Gibbs Award, is presented for unparalleled service to the Medical Service Corps community and to the Navy.

The Admiral David Sullins - Junior Officer Leadership Award recognizes service to AMSCON as well as outstanding contributions to the Navy as a Medical Service Corps officer. This award is specifically targeted to recognize the contributions of ensigns through lieutenants.

This year the Admiral David Sullins - Junior Officer Leadership Award was awarded to LT Kirt Nilsson. LT Nilsson is the officer-in-charge of the Information Management Department, the Department Head for Patient Administration, and the Decedent Affairs officer at Naval Health Clinic Cherry Point. He was nominated as a shining example of the ideal healthcare administrator, patient-centered, solution-focused and a team player. He is praised as professional, articulate, intelligent, gregarious, and hardworking—truly a "go-to" officer.

The Clarence J. Gibbs award was awarded to CDR Angela D. Adams. CDR Adams is assigned as the Senior Medical Officer and Medical Planner for Naval Reserve Fifth Fleet Maritime Operation Center in support of Commander U.S. Naval Forces Central Command and serves as a member of the Crisis Action Response Team. She was nominated as an outstanding Naval Officer with dynamic leadership qualities and for her dedication as a Navy pharmacist and representative for numerous community activities. Her accomplishments and leadership promote the advancement of pharmacy and her efforts as a mentor have brought the Navy principles of honor to hundreds of young Americans.

Published by the Association of Medical Service Corps Officers of the Navy.

MSC and MC Officers Awarded Bronze Star

CDR Ed Cornwell, MSC, and CDR Ed Taylor, MC, received the Bronze Star for their participation in the reconstruction efforts in Al Anbar Province, Iraq. CDR Cornwell served as the Health & Medical Advisor for the Embedded Provincial Reconstruction Team and CDR Taylor served as Regimental Surgeon for Regimental Combat Team 6. Together, they combined efforts to rebuild the Public Health Care System within the city of Fallujah.

They established the first ever Fallujah Healthcare Council, a joint military and civilian healthcare team comprised of Iraqi and coalition healthcare executives and physicians. Its primary purpose was to establish a baseline of health parameters and a streamlined process that expanded vital civilian medical services in the Fallujah battle space.

The Council achieved a landmark event by coordinating

The Fallujah Healthcare Council. Left to right: CDR Ed Taylor; Dr. Ammar, Internal Medicine; Fallujah General Hospital Operations Officer, CDR Dan Cornwell; Dr. Ismail, Orthopedic Surgeon, Fallujah General Hospital Chief Executive Officer. Photo by MSGT Jason Salazar, USAF

the first "face-to-face" coalition and Iraqi physician conference, bringing together more than 50 physicians from Fallujah and coalition forces to begin dialogue on the future healthcare needs of Fallujah. The conference allowed for better understanding and dialogue between Iraqi and coalition providers and was a key factor in the rebirth of the Fallujah healthcare system.

Working as a team, CDR Cornwell and CDR Taylor managed and executed 12 healthcare projects valued in excess of $5 million dollars; opened 3 new public health clinics in conjunction with combined medical engagements treating over 2,300 Fallujah citizens; and executed over $1 million dollars in equipment, renovations, and cleanup to Fallujah General Hospital.

Their accomplishments represented Navy medicine at its best: working with multiple agencies, both foreign and domestic.

–Story by LT Steven Bailey, MSC, USN.

NHB Nurse Spends More than a Year Advancing Skills of Afghan Counterparts in Kabul

Lack of medical supplies, poor sterility techniques, and language barriers were not what LT Paul Obertone was expecting when he reported aboard Naval Hospital Bremerton as a perioperative nurse. However, those were the conditions he was helping solve during his recent 15 month deployment to the National Military Hospital in Kabul, Afghanistan.

As part of a 20-man team sent to train the local medical staff, Obertone spent more than a year not only helping the hospital supply itself and teaching medical techniques, but also helping set the groundwork for the teams that followed to continue the work initially started.

The National Military Hospital (NMH) sat at the center of a web of regional hospitals which had received visits from U.S. medical training teams in the past. When Obertone's team arrived on the scene in August 2007, though, they were the first to tackle the NMH. "Regional hospitals have been getting a lot of attention, but not this one," he said. "The 'Bethesda' of the Afghan Army had been kind of neglected."

Obertone said there were some hurdles to cross even before they could get down to the mission of training the hospital staff. Living arrangements, transportation, and supply lines all had to be established first. Smack dab in the center of Kabul, the team members even had to provide their own security and force protection. As a multi-service task force, there was also a lot of work put in to learning how to "do things the Army way," for example. According to Obertone, it took more than a month just to lay the groundwork.

"We were the first for the NM, so we did a lot of trail blazing," he said, noting that some of the satellite clinics got mentoring teams, but Obertone and his group were the first to work out of the core building.

LT Paul Obertone (in uniform) poses with his OR nursing counterparts and their translator at Kabul, Afghanistan's National Military Hospital surgical center. Photo courtesy of LT Obertone

The training team itself was made of a variety of hospital specialties such as hospital administrators, surgeons, and pharmacists. Each teamed up with their counterpart from the hospital to mentor them and introduce them to medical advances they might not have seen. As an OR nurse, Obertone worked closely with the surgery team to improve their patient care. Cleanliness was his first challenge, ranging from teaching proper handwashing techniques to simply setting up smoking areas outside the surgical areas. He also worked with locals to manufacture scrubs in enough quantity that the surgical teams had enough clean sets to go around. All this was done with the mind set of mentoring for future success.

"Teaching them how to fish instead of handing them a fish," he explained. "It really is cliché, but it's to the point."

"It's easy to just go in and do it for them, but that's not mentoring," he added. "What I had to do was say 'how can we best prepare these people to do the best job they can if we had to leave tomorrow?'"

Looking back at his 15 months there, Obertone sees his successes as numerous small victories rather than one big triumph. Even at a year-plus, the team's time there wasn't enough to accomplish everything they'd set out to do. In the long-term, though, their focus on teaching the hospital staff to teach themselves was the main goal. With that objective reached, there's a promise that Kabul's NMH's level of care will only get better.

–Story by MC1(SW) Fletcher Gibson, Naval Hospital Bremerton Public Affairs.

NOMI Unveils Plaque in Honor of POW Researcher CAPT Robert E. Mitchell

Retired CAPT Robert E. Mitchell, naval flight surgeon and honorary naval aviator, was recognized with a bronze plaque on 15 October in the lobby of the building named for him—the Robert E. Mitchell Center for Prisoner of War Studies at Naval Air Station (NAS) Pensacola, FL. Former POWs, their families, and NOMI officials were present with Mitchell as the plaque was revealed. A group of former POWs organized the purchase of the plaque, which is similar to those in the National Naval Aviation Museum's Hall of Fame. "They got together in recognition of Dr. Mitchell's 36 years of devoted efforts in supporting them," said CAPT Robert Hain, MC, USN (Ret.) executive director of the NMSC/NOMI Robert E. Mitchell Center for the Prisoner of War Studies. "His life as a physician has really been dedicated to them." The group of mostly Vietnam POWs have a very close bond with Mitchell, who worked after the war as a "personal physician" to the group and laid the groundwork for long-term studies of former POWs. CAPT Jim Hickerson, USN (Ret.) was one of those behind the effort. Hickerson, a former naval aviator and POW, has known Mitchell since

CAPT Hain congratulates CAPT Mitchell (left) at the unveiling of a commemorative plaque in his honor. Photo by Mike O'Connor, *Gosport* Staff Writer

1973. "Bob Mitchell is like family," Hickerson said. "He's got this building named for him; it was simply time to do this." A collection was started with about 200 vets contributing to the effort, Hickerson said. "This is great. Totally unexpected," Mitchell said. "It's been a tremendous privilege to work with these people. I'd have to say it was the highlight of my life," he added. "And I thank all of you. All of the POWs are our heroes," Hain said at the ceremony's conclusion. "But this is the biggest hero of all."

–Story by Mike O'Connor* Gosport *Staff Writer.

HMC(SW) Zano (right) is congratulated by CAPT Yves Nepomuceno, OIC, Surface Warfare Medicine Institute. Photo by LTJG Shani Henry, MSC

"While serving as convoy medic during a convoy reconnaissance mission, his High Mobility Multipurpose Wheeled Vehicle was severely damaged by an explosively formed penetrator (EFP). HMC(SW) Zano displayed exceptional leadership and medical skills by rallying on short notice with his unit's quick response force convoy to provide initial medical treatment to coalition convoy personnel injured during an EFP attack. He was the only medical person available and he provided lifesaving medical care above and beyond his scope of practice. HMC(SW) Zano honored the finest traditions of military service and reflected distinct credit upon himself, the Multi-National Security Transition Command-Iraq, and the United States Navy."

–Story by LTJG Shani Henry, NOMI Public Affairs.

NOMI HMC Receives Bronze Star For Actions Following IED Attack

I was simply just doing my job," HMC(SW) Joven M. Zano told a group of Naval Operational Medicine Institute (NOMI) instructors, students, family, and guests recently at the presentation of his Bronze Star.

"When I first volunteered for this Individual Augmentee duty, I had no idea that I would be part of a transition team mentoring our Iraqi counterparts in a remotely located Iraqi FOB (Forward Operating Base)," Zano said. " I owe my actions to my mentors who taught me to become a better medical provider and to the years of experience in the operational medical field which tremendously helped me in carrying out my job."

According to the award's citation, "HMC(SW) Joven M. Zano, United States Navy, distinguished himself by exceptionally meritorious service as senior medical advisor, An Numaniyah Military Training Base, Coalition Army Advisory Training Team, Multi-National Security Transition Command Iraq, An Numaniyah, Iraq.

HM3 Eichmann A. Strickland, 23, of Arlington, WA, died 9 September from injuries suffered when the vehicle he was driving hit an improvised explosive device in Afghany Valley, Afghanistan. He was assigned to Combat Service Support Det. 36, Iwakuni, Japan. He was a member of a Marine embedded training team deployed to Afghan Regional Security Integration Command Central.

Continuing Promise 2008

The lines form early and snake through the muddy paths of the northern city of Gonaives. Women stand patiently, waiting for food. They stand in the line among hundreds of others after walking miles under the sweltering sun. They do not complain; they do not push or shove. These Haitian women wait patiently because they know, with absolute certainty, that at the end of the line there is food waiting for them. At the end of the line sits the bags of rice and beans, and jugs of cooking oil, that our crewmembers delivered to this devastated area.

This line of women ends at one of the distribution points for food. During his visit, RADM Joseph Kernan wanted to see for himself what happens to the food once our helicopters drop it off, and once our volunteer working parties heave it out of the helicopters and lug it to the beach. RADM Kernan recounted later of the women's fortitude, of seeing the thankful looks in their eyes as they received their food and placed it on their heads to begin trekking the miles back to their homes.

Today we delivered 142 metric tons of food, and 3,600 2.5 gallon bags of water to many cities in Haiti.

Our crewmembers labored long into the day again. Meetings at the U.S. Embassy illuminated more support for us to provide to Haiti. Our doctors attended a meeting chaired by the Assistant to the Minister of Health. Present at this meeting were different NGOs, including Doctors Without Borders. A representative from Doctors Without Borders described the invaluable impact of Team Continuing Promise's support and assistance. Before we arrived, he said, "they only distributed 20 tons of food in 5 days. With our heavy lift capabilities we are now moving 120 tons every day. Our doctors are coordinating with our NGO partners and the Ministry of Health of Haiti to assess outlying areas."

A child holds medication given to her by medical personnel. Photo by MCSN Joshua Adam Nuzzo, USN

RADM Joseph Kernan, Commander, U.S. 4th Fleet helps military personnel unload disaster relief supplies. Photo by MCSN Joshua Adam Nuzzo, USN

A Haitian woman receives canned goods from U.N. officials. Photo by MCSN Ernest Scott, USN

Canadian Army CAPT Gillian Batt from the Canadian Disaster Assistance Readiness Team A acts a translator for medical teams. Photo MC1 Amy Kirk, USN

Canadian Forces CPL Eva-Marie Rogerson has a touching moment with local village child during a medical assessment. Photo by MC2 Erik C. Barker, USN

The U.S. Ambassador to Haiti received a brief from Team Continuing Promise engineers after days of assessing the bridges and infrastructure. Our expertise and assessments provide invaluable information to rebuild this country.

There are so many components and players involved in this mission to alleviate the suffering of the Haitians—heaving and stacking bags of food and water, communicating and coordinating with the Haitian government and NGOs, sharing expertise and experience within the medical and engineering fields. Yet in the midst of heavy airlifts and plans, our aircrew responded to a special request. We had received a report of an American citizen who desperately needed our help. This American citizen was a 73-year-old woman. She has Type II diabetes and was having complications; she had no medication and needed to travel to Port-au-Prince, an impossible task right now except by aircraft.

When our helicopter landed at Gonaives, this woman slowly emerged from the back of an ambulance. I met her and helped her hobble toward the waiting helicopter. One of our aircrew watched her slow approach to the helicopter, and when she arrived he immediately dropped to one knee, as if to ask for her hand in marriage, and used his other knee for her to step into the waiting helicopter. I was moved passionately, but NOT surprised, by this sincere gesture of kindness. It is the kind of human spirit that the men and women display every day and one that no matter how many times witnessed, always bring a sense of pride to be in command of such a fine and honorable bunch.

During the flight to Port-au-Prince this elderly woman motioned that she was hungry; I gave her a Kashi granola bar filled with nutritious little peanuts. When we landed at the airfield, she looked at us, said "God Bless you," and disappeared into the heat of the day in search of medication.

Every crewmember sees the role they each play in the aftermath of the storms, and tonight as the sun sinks behind a layer of squally clouds sure to bring more rain in the days to come, we can rest for a few hours, knowing our tremendous efforts helped hundreds of Haitians to sleep tonight with full bellies and peaceful knowledge that we care. There is much to be done so I must get back to the business at hand—helping and giving. It is what we are here to do.

–Excerpt from the blog of CAPT Frank Ponds, USN, Continuing Promise 2008 Mission Commander.

BACKGROUND: Haitians follow medical personnel from USS *Kearsarge* (LHD-3) to a neighborhood school where medical care is provided. Photo by MC3(SW) David Danals,USN

LT Pandora Liptrot, NC, and CPL Nathalie Rogerson, a Canadian Forces medic, administer intravenous fluids to a severely malnourished infant at the temporary medical clinic set up at the Center of the Grace of Good Samaritan Orphanage. Photo by MC3 Maddelin Angebrand, USN

CAPT Tim Shope, medical augmentee, listens to the lungs and heart beat of an elderly woman. Photo by MCSN Joshua Adam Nuzzo, USN

U.S. Public Health Service CDR Dale Bates entertains local children with photos after conducting a health assessment in their village. Photo by MC2 Erik C. Barker, USN

EDITOR'S NOTE: USS *Kearsarge* (LHD-3) is now back on her Continuing Promise 2008 plan and is in the Dominican Republic. She will return to her homeport, Norfolk, VA, 1 December.

A Girl Named "Kirk"

HMC Stephen Burwinkel, USN (Ret.)

The fall of Saigon in April 1975 triggered "Frequent Wind" a massive rescue operation of U.S. personnel and South Vietnamese closely associated with American presence during the war. The operation involved 44 Navy ships, 6,000 Marines, and 120 Air Force tanker aircraft. Frequent Wind produced unintended consequences. Without warning, thousands of other Vietnamese also fled their homeland and headed for those vessels standing by offshore. South Vietnamese pilots set their aircraft down on already crowded flight decks, creating indelible images of the war's finale. Empty of fuel, some choppers were forced to land in the sea. Looking like dying birds, they beat their rotors to fragments. As men, women, and children swarmed from aircraft, Navy crewmen stripped the helos of any useable equipment. The helicopters were then shoved over the side to make room for more incoming aircraft with cargoes of refugees.

One of the vessels in the rescue fleet was USS* Kirk *(DE-1087). The nearly 4-year-old vessel was designated a destroyer escort specializing in anti-submarine warfare, but at 438 feet in length,* Kirk *was much larger than her World War II forebears.* Kirk*'s independent duty corpsman, HMC Stephen Burwinkel, represented the vessel's small two-man medical department. Independent duty meant that as a highly trained and experienced petty officer, he worked without supervision of a physician. His patient load was soon to increase.

It was 28 and 29 April when all hell broke lose and Saigon fell. Operation Frequent Wind really started for us on the 29th when we began taking on refugees. Our LAMPS [Light Airborne Multipurpose System] helicopter was fortunately broken at the time because it was in the hangar and not on the flight deck when the first Vietnamese helo landed. Soon another one landed on our flight deck and that filled up the deck.

I was truly amazed when the second pilot landed. I thought, "He can't put this thing down here." But sure enough he did. Then the helicopters started coming out like butterflies or hornets circling around us and other ships.

We had to push those first two Hueys over the side to make room for other incoming choppers. Another one landed on our fantail so that filled up the flight deck again. To get that Huey on the fantail out of the way, our LAMPS pilot flew it off the ship then re-landed it on the flight deck. So now we had two more Hueys up there.

At that point, a CH-46 [Sea Knight helicopter] came along and the pilot acted like he was going to land. When he saw that our flight deck was fouled [obstructed by aircraft]

and couldn't land there, he came around toward our fantail. But it was obvious that he couldn't land there either. Our first class storekeeper [Jeffery Swan] spoke some rudimentary Vietnamese. He got on the radio and in very broken Vietnamese told the pilot not to land. The pilot then hovered about 10 feet over the fantail and people began jumping out the back.

Some incurred minor injuries such as broken ankles, but most refugees were uninjured. In fact, quite a few unsung heroes among our crew began catching these refugees. One mother threw her little 4-year-old boy out and a sailor caught him just like he was catching a baseball out of the sky.

After the helo was empty of passengers, the pilot flew some distance from the ship, rolled the helo on its side, and landed it in the water. When it hit, rotor blades went everywhere. When all the debris stopped flying around, he climbed out the window, jumped into the water, and popped to the surface. By that time our motor whaleboat was in the water to pick him up.

Soon we were maxed out with about 150 refugees aboard. Good old CAPT [Paul] Jacobs, being the hard charger he was, went around looking for more. In fact, he came to sick bay all excited and said, "Doc, I think we found a lady who's pregnant!"

I said, "Skipper, we don't need any pregnant women on this ship." As it turned out, we ended up with five pregnant ladies.

"Please, Doc," he said, "tell me that one of these ladies will have a baby aboard ship."

That possibility didn't really cause me any anxiety because a previous tour in Morocco included duty in the delivery room. The process of a woman giving birth wasn't fearful to me. My third class [petty officer], in fact, asked me, "Chief, what are we gonna do if one of these ladies has a baby?"

"I assume we'll witness the miracle of birth," I replied.

As it turned out, one of the women went into labor but then stopped. None of them delivered aboard ship. In a space we called the "Ballroom," we had set up a mini maternity ward and that's where we kept these five pregnant women under observation.

The refugees were in pretty good shape despite the fact that I had some concerns I had voiced to the skipper. I thought about tuberculosis, dysentery—all the diseases endemic in Vietnam. But these refugees were the upper crust of Vietnamese society. They were wives and family members of Vietnamese officers and were wealthy enough to get out first. In fact, many came aboard with shoe boxes full of gold, which we confiscated to prevent a situation in which theft might occur. We gave the people a receipt. Our supply officer collected a lot of gold.

We rigged up some canvas awnings on the O-1 level and refugees were soon living up there. We also granted them some head privileges. But the 150 refugees we had taken aboard taxed our food and water situation.

Kirk was then ordered to move down to Con Son Island near Vung Tau. When we got there on the 1st of May, we found what was left of the Vietnamese fleet. And this is when all the fun and games started for me. Between rendezvousing at Con Son Island until we got to the Philippines, I spent all my time going from ship to ship to see what I could do for these refugees. I was basically holding sick call.

A first class bosun's mate and one of the other chiefs went with me. They went aboard to make sure that these people weren't armed. I can't tell you the number of .38 caliber pistols, shotguns, and rifles that we threw into the South China Sea. As we found these weapons, we tossed them over the side.

The refugees seemed to be very relieved that the initial danger was over. They were out of Vietnam. They were away from all the hell and disorder in Saigon. They were very apprehensive, of course, because they didn't know where they were going. In many cases, families had been split up. Mom was there with the kids. Who knew where dad was or vice versa? But generally, they were a calm, cool, collected group of people considering what they had just been through.

I discovered two Vietnamese armed forces physicians on one of these refugee ships. Both spoke pretty good English. I thought my luck had changed. I said, "When I go back to the ship and get some more supplies, I'll bring you stethoscopes and whatever else you need."

One answered, "No, the war is finis. And we are finis." They would not offer any assistance.

I said, "At least I'll bring you back some medical supplies."

The other answered, "No, we're not doing anything. We're refugees like everybody else."

I was pissed, to put it very plainly. "Wasn't this typical," I thought. "No wonder these guys lost the war."

Sometimes I'd go back to *Kirk* during the day to replenish my supplies, such as Ace bandages and battle dressings. Usually I'd do these medical checks until dark, then come back aboard to get something to eat and change my clothes. Then I'd start out again the next morning. A few times because of certain circumstances, I spent significant time aboard some ships—sometimes all night. I didn't want to take the chance of trying to find *Kirk* in the dark.

These refugees had a lot of minor medical problems. I saw many cases of conjunctivitis caused by the unsanitary conditions and being worsened by exposure to the sun. Conjunctivitis—pink eye—is highly contagious. In fact, if I caught it, I was afraid that would be the end of it. Your eyes get swollen and you can't see.

I quickly ran out of ophthalmic ointment. I desperately needed something to treat diarrhea, large amounts of antibiotic ophthalmic ointment, and diapers. A C-130 arrived and dropped barrels of supplies. I think

I had more Kaopectate and Lomotil than I had ever seen in my life.

One of the problems that contributed to this horrendous scenario was the unsanitary situation. The ships discharged wastewater directly from the heads into the sea, especially the older ships. The Vietnamese on the aft end of the ships would get water out of the sea to wash their faces and bodies so they were using water contaminated with fecal material. I tried to explain to more than one commanding officer not to let the people do this but instead to insist that they go up forward and get their water. In most cases, however, this was impractical because the freeboard [distance between the water and the main deck] up forward was too high and they couldn't lift a heavy bucket successfully. They could do it at the aft end where there was less freeboard.

After the third day, I began seeing upper respiratory problems and some trauma. One situation was very unusual. I came across a man on one boat who had been gut-shot. I could see his intestine and that's why I thought he couldn't survive but would probably die of peritonitis. I noticed that he had already been treated by someone. He had a dressing and what looked like sulfa powder. A Vietnamese officer wanted me to take him back to *Kirk* but I didn't know what I would do with him back on the ship.

But he ended up back aboard *Kirk*, and I waited for him to die. I opened up the table in what we called the "after battle dressing station" and inserted an IV. I then got a young third class [petty officer] and showed him how to take blood pressure and change the IV. Then I said, "This guy is yours until we reach the Philippines or he dies. Don't give him anything to drink except to wet his lips."

But the old coot didn't die. When we got to the Philippines, he was taken to surgery at [Naval Hospital] Subic Bay. Afterward, he did just fine—sitting up and smiling. He was a tough old man.

We came across a large civilian freighter—the *Tan Nam Viet*—which was loaded to the gills with refugees. The XO, a few other people, and I went aboard that ship. That's when my adventure started. I recall what Dick McKenna, the XO, said: "Doc, you need to stay aboard and see what you can do for these people. And I'll be right back in about 4 hours to get you." Two days later they came back and got me.

Of course, I didn't have a lot with me. I had my Unit 1 and some penicillin. We identified a woman who spoke some English, and I used her as my interpreter. She brought me a baby I thought was already dead. The baby was listless and unresponsive. I listened to its lungs and determined it was still alive but was in very bad shape, probably pneumonia.

I had no way to figure out the baby's weight and what the penicillin dosage should be. But I administered a great big dose of penicillin. And I'll be darned if it didn't work. The next day this baby was not only alive and well; it was pretty pissed off! It was hungry and crying.

I recall another incident. An LSM [Landing Ship Medium] we had given the Vietnamese showed up in very bad shape loaded with refugees. I went aboard and could see that the ship, which was taking water through the bow doors, was sinking; the doors wouldn't close properly. A young Vietnamese lieutenant was acting as the CO. I asked him if he spoke English and he said yes.

"Do you know your ship is sinking?"

He answered, "Yes, I know that."

At that point we went alongside another Vietnamese Navy ship and that's when the refugees on the well deck and the deck above it realized the ship was sinking—and they panicked. As we were close by the other ship, the crew put two wooden gangways across to that vessel. Then one of the men panicked and pushed a woman in front of him and she fell into the water. I don't know what happened to her after that. A Vietnamese officer walked right behind this man, put a gun to his head, and executed him right on the spot. Suddenly it was just like a church. Everybody quieted down and went over to the other ship without further incident.

One refugee had a severe leg injury, a compound fracture of the femur. I applied a Thomas half-ring splint to

PHOTOS COURTESY USS *KIRK* ASSOCIATION

Crammed with refugees, *Tan Nam Viet* wallows dead in the water awaiting assistance.

immobilize his fracture but could see that he had to have open orthopedic surgery, which meant getting him to a ship with a doctor. That ship was *Flint* [AE-32], which had a physician and an operating room.

Remember that we had taken two Hueys aboard *Kirk*. The front end of one and the back end of the other had been damaged. Our LAMPS detachment took the good front end and the good back end and married the two to make one good Huey.* Then we loaded this refugee with the leg injury in a Stokes stretcher and got him on the now functioning Huey. One of our LAMPS pilots did the flying.

In taking off, we snagged one of our radio antennas and tore a hole in the bottom of the Huey. We had to land so they could patch the hole with duct tape; then it took off again. Of course, I was sitting back on the deck of the helo because all the seats had been taken out. The pilot said, "Hey Doc, if something happens and we go in the water, you need to push yourself out the door, pull those things on your Mae West, and you'll pop to the surface."

I remember responding to the pilot through the mike, "What about this guy who's in the Stokes litter?"

One of the pilots answered: "He's bought the farm [been killed]." When we landed on the flight deck of *Flint*, they took the guy off and we left. I assume the man made it. At least I hope he did.

Caring for the pregnant women was one of the jobs that cut into my time. After I did my rounds during the day, I'd come back, they'd tie the Swift boat up, and we'd tow it along as if it were an extra lifeboat or dinghy. My third class corpsman, Mark Falkenberg, and I would compare notes and catch up. It might be 11 at night or midnight before I got a few hours of sleep.

In the morning, we'd get the engine started on the Swift boat, which often was not immediate. It was long overdue for an overhaul. Then I'd go up and down the lines of boats doing my rounds.

Luckily the weather held during our crossing to the Philippines—no bad storms. That was good because some of those boats would never have made it had we gotten into some heavy seas.

We had only one real tragedy. A young mother with five or six children had been brought aboard *Kirk*. One of them, a boy about a year old, had pneumonia. He responded to treatment and was doing real well. For all practical purposes, he was cured. But while I was out on my rounds, the first class bosun's mate said, "Doc, we just got a radio message and we've got to get back to *Kirk* right now." When we returned to the ship, I found that the mother had been feeding the baby a bottle. He coughed and aspirated the formula from the bottle. Due to his compromised lungs, he died.

Somehow, we found the father on one of the other ships, and brought him to *Kirk*. Then we had a formal burial at sea of this little baby. That really shook me up.

By this time we reached Subic Bay and unloaded our passengers, our ship was in total disarray. Our daily cleaning routine had come to a screeching halt. I was stripped of all my supplies.

When we arrived in Guam, we had a reunion with some of the people from the *Tan Nam Viet*. In fact, the first of the pregnant ladies [Lan Nguyen Tran] gave birth on Guam. If it was a boy, she promised to name her child "Kirk." But it was a girl so her middle name is "Kirk."

**Kirk*'s chief engineer, Hugh Doyle, recalled the specifics of this operation: "*Kirk*'s aviators removed the tail pylon, drive shaft, and tail rotor from one of the helicopters we were preparing to throw over the side, and replaced the damaged tail assembly on the helicopter we had saved up on the port side of the flight deck. This 'cannibalization' took only a few hours, and the repaired Vietnamese helicopter was then pushed back into position on the flight deck, refueled, and made ready for one more mission."

Baby Kirk with her mother at 4 months.

Stephen Burwinkel retired in 1989 after a 30-year Navy career, and then worked for CHAMPUS and Humana. He retired "for good" in 1997, and makes his home in Pensacola, FL.

An Honest Depiction

Painting by Morgan Wilbur.

A New Angle on an old Act of Heroism

It was Nimitz Day, 5 October 1945, a day set aside to honor Fleet Admiral Chester W. Nimitz's, recent wartime service as Commander-in-Chief, Pacific Fleet. On the White House lawn, an 18-year-old former hospital apprentice stood before President Truman while his Medal of Honor award citation was read aloud. "For conspicuous gallantry and intrepidity…serving as corpsman with a rifle company, in action against enemy Japanese forces on Okinawa Jima…Fearlessly braving the fury of artillery, mortar, and machine gun fire from strongly entrenched hostile positions…he was advancing to administer blood plasma to a Marine officer lying wounded on the skyline when the Japanese launched a savage counterattack. In this perilously exposed position, he resolutely maintained the flow of life-giving plasma. With the bottle held high in one hand, Petty Officer Bush drew his pistol with the other and fired into the enemy's ranks until his ammunition was expended. Quickly seizing a discarded carbine, he trained his fire on the Japanese charging point-blank over the hill, accounting for six of the enemy."

As young Robert "Bob" Bush stood there among other Medals of Honor heroes and hundreds of distinguished guests, he scarcely recognized the action attributed to him. The words of the citation, which would forever interpret what happened on 2 May 1945, and would inspire several artistic renderings, were just simply wrong. The real story was much more dramatic and far more remarkable.

Some 63 years after Bush's heroism, and 4 years after his death, two men—an historian and a painter—have set out to get the record straight.

The Historian's Call to Arms

"I've always been bothered by the fact that paintings and other illustrations of the incident for which Bush received his Medal of Honor were inaccurate and somewhat fanciful," Jan Herman revealed in a recent interview. "They were stylized and heroic but just plain wrong. Bush told me a story that was totally different from both the artistic depictions and the words of the award citation."

Jan Herman is the Navy Medical Department's senior historian. Since the early 1980s he has been interviewing and capturing the stories of Navy medical personnel of bygone days. The result of the "oral history project" has inspired three books as well as a six-part documentary series about the Navy Medical Department's role in World War II entitled "Navy Medicine at War." In 1994, Herman interviewed Robert Bush about his wartime service. What he heard did not match the recorded account.

"It certainly fit the model for those types of award citations. The heroic corpsman goes out and braves fire-swept fields, dodges grenades, and ignores mortar fire to reach a downed Marine. Then, with his own life at mortal risk, he renders first aid. In this case, the citation emphasized that Bob Bush, even though he himself was gravely wounded and still under fire, refused evacuation

until his patient was successfully evacuated. Well, that turns out to be untrue. According to Bush, his patient evacuated himself."

In an interview with Herman, Bush related the real story. The novice Marine lieutenant, who had just recently joined the company, made a hasty decision to assault a well-defended hill. In doing so, he and several other Marines were caught in the open and felled by enemy fire. All but the lieutenant were killed. Seriously wounded, he fell into a shallow bomb crater just yards from the enemy.

What happened next would forever change Bob Bush's life. The young hospital apprentice did what hospital corpsmen are trained to do. With two well-armed Marines providing cover, he rushed to the lieutenant's aid, jumping into the crater beside him. As Bush remembered, "I immediately noticed that his eyes were dilating and I knew I was losing him. I put a battle dressing on his shoulder, opened a can of serum albumin, and put the needle in his vein. I looked on that ridge and was scared to death. I then grabbed his carbine and dropped the clip into my left hand. As I again reviewed the hill, suddenly a head popped up. I was still holding onto the albumin can. Suddenly, I felt a tug on the can. I let go of it and up jumped the lieutenant out of the hole and across the rice paddy back toward our lines, dragging the can behind him. When he took off, the top of that hill just opened up.

"I didn't bother looking back at the lieutenant. I had immediately written him off. I grabbed the carbine and, with the help of God, I was able to see the Japanese sticking their heads up. As scared as I was, I knew I had to fight or die. There were no alternatives."

"Right about that time, the hand grenades started coming in. They knew where I was. As the first one hit, I threw my arm up over my face but my right eye was already gone."

Although seriously wounded with one eye shot away and fragments in his chest and shoulder, Bush continued his one-man fight for survival. "I fired my carbine until it went empty, then emptied my .45 and threw it away."

Bush had decided that remaining in the shell hole was not an option. Taking advantage of a disturbance on the field of battle that momentarily distracted the Japanese, he found a way to cross in front unseen and flank their position. He then made his way around the hill to the top, picking up a discarded M1 rifle on the way. He was now behind the Japanese.

"They had their backs to me, four of them lined up like dominoes. I had the element of surprise and needed all the advantage I could. Just holding that rifle in my condition was a real effort. I walked along that ridge and winged every Japanese I saw." Suddenly finding himself alone, the gravely injured corpsman limped back to friendly lines.

Herman reminds us that, in addition to the written word, pictures can also influence our image of the "truth."

"There had been several images of Robert Bush in books and one famous illustration painted by the renowned Marine combat artist, COL Charles Waterhouse." Waterhouse's picture depicts Bob Bush down on one knee with his .45 automatic pistol firing at the Japanese who are now descending upon the wounded patient and corpsman.

This past spring, Herman began mulling over the idea of commissioning a painting that would accurately depict what had actually happened on Okinawa in May 1945. He shared his thoughts with Morgan Wilbur, a second-generation Navy artist, who has worked with the Navy Medical Department in the past. Needless to say, he was more than receptive.

"I thought it was a great idea," says Wilbur. "Anything that highlights what our folks did in the past is good. It informs people and offers lessons for us today."

After accepting the commission, Wilbur began researching Bush's career and the "incident." He read Herman's oral history transcript, looked through photos of Okinawa at the Naval Historical Center, and read books about the battle. He sought out information concerning soil and climate, as well as the weather conditions at Okinawa on 2 May 1945.

The U.S. Marine Corps Historical Company, made up of retired and active duty Marines, and dedicated to interpreting Marine Corps history, agreed to provide models dressed in period uniforms with authentic World War II weapons and medical gear.

Wilbur took more than 60 photographs of the models, developed an idea of perspective, which ultimately led to what the painting would look like. "The hardest thing was to decide a vantage point for the viewer. I usually let it percolate overnight. I went with ground level over to the side."

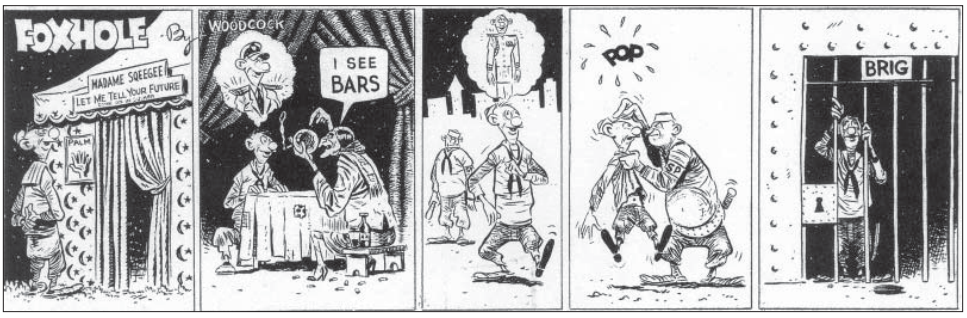
Wilbur finished his painting in early September. It depicts Bush kneeling over his patient in a muddy shell hole with a light drizzle falling from a leaden sky. He has just applied a battle dressing to the lieutenant's wounds and administered a bottle of serum albumin. Holding a carbine in one hand and a spare magazine in the other, the corpsman-warrior is frozen in time.

As Wilbur reminds us, unlike many of the contemporary themed paintings he normally does, recreating a historical incident has its own hurdles that one cannot simply jump over. "I tried to make this painting as accurate as possible. But despite all the research, I couldn't escape the fact that I wasn't there to witness the action. Even so, one basic fact remains unmistakable; Bob Bush's action on Okinawa Jima in World War II was heroic."

Wilbur's painting of Hospital Apprentice Bob Bush is now part of the official Navy Art Collection, and will be featured in the next installment of Jan Herman's Navy Medicine at War series, entitled "Final Victory." In evaluating Wilbur's "reinterpretation" of Bob Bush's Medal of Honor brand of heroism, Herman asserts, "I always feel it is the historian's job to reevaluate the evidence and correct the record. With Morgan Wilbur's painting we have accomplished this."—ABS

Woody's World

The Story of the Navy's Corpsman Artist



CARTOONS COURTESY OF ROBERT WOODCOCK

Pharmacist's Mate Second Class Robert G. "Woody" Woodcock was not your typical World War II hospital corpsman. Despite his rating, he was not a medical man but a talented cartoonist and illustrator who spent the war elevating the spirits of his colleagues with Navy-themed comic strips. Sixty-three years after he left the Navy, we caught up with Robert Woodcock to learn more about his unique service.

The Seattle-born and -bred Woodcock graduated from high school in 1938 and the Burnley School of Art (now known as the Seattle Institute of Art) in 1940. After leaving art school he got a job as an illustrator for a local department store newspaper. He was earning a steady paycheck and preparing to become engaged to his girlfriend, when his budding future expectations were shook up by an unfortunate reality of life, a seemingly harmless piece of mail arrived. "I received my draft notice and knew I had to report to the recruiting office in Bremerton to enlist," Woodcock remembered. "I had hoped to become an aviation machinist's mate. When I took my physical, I learned that my heart beat too fast and I could not join the Navy."

Week after week Woody went back to the recruiting office hoping that either they would change their minds or his heart condition would be deemed satisfactory. Soon after getting married, Woodcock returned to the recruiting office and, as he put it, "They finally took me in."

In 1942, while at basic training in San Diego, Woodcock received two surprises that would ultimately shape his military career. First, this hopeful aviation machinist's mate was selected to attend hospital corps school. And second, "I learned about a military art competition." Woodcock submitted his art and won first prize in the San Diego area and third prize in the United States, getting beaten by a young G.I. artist named Bill Mauldin. In addition to a $25 prize, Woodcock earned moderate fame in the Navy as a talented artist.

Admittedly, Woodcock struggled through corps school and did not think he could graduate. But Woody offered more to the Medical Department than just medical prowess. "The Navy had a variety of uses for someone with artistic abilities. So I found no trouble finding my niche within the Navy Medical Department. Soon after a short stay at Naval Hospital Bremerton, I was transferred to Bethesda and the Medical Illustrator School where I spent the next 18-months honing my skills."

It was at Bethesda when Woodcock was commissioned to paint BUMED Building Two for the Medical Center's command suite. The BUMED building, a National Historic Landmark, had previously served as the home of the Naval Medical School (1902-1942), Naval Museum of Hygiene (1894-1905), and Naval Observatory (1844-1893). In 1944, it was operating as BUMED's "Hospital Corps Records Branch."

Using photographs taken of the installation—and never actually visiting the facility—Woodcock completed in 3 months what would be his first oil painting. Remarkably, Woodcock was not aware of the exact significance of the building at the time nor what would become the first of several hundred paintings.

"I had no idea what had happened to the BUMED painting, but did wonder from time to time what may have come of it. It is very warming to know that it has been preserved, has a good home, and can still be viewed."

Upon completion of the painting, Woodcock was ordered to Naval Hospital Aiea Heights, HI. It was there that he developed a weekly comic strip called "Foxhole" for the hospital's newsletter, *Hi-Lites*. Foxhole, the title character of the strip, was a somewhat dim-witted, but well-meaning sailor who never failed at finding trouble. In a "biographical study" of his title character, Woodcock wrote that Foxhole grew up in "Podunk" and was "'born to the bottle,' as it were, since his mother took one look at him after birth and promptly collapsed. She didn't recover until he was 8 years old, 1 year after he had demonstrated his precocity by weaning himself."

In his own words Woodcock admitted that the strip, "drew upon many of the day-to-day situations both on and around the base. Since I kept his character localized, the men loved it and it became a great morale booster during those difficult times."

At the hospital, Woodcock also drew many "single frame" cartoons, under the

title "Aiea Antics," as well as a number of posters and informational cartoons regarding the so-called perils of "social interaction." His many creations became well known and earned him much, as he puts it, "fame without fortune." At one point, the popular cartoonists George Baker and Marion Hargrove, who earned renown for their respective strips "Sad Sack and "See Here Pvt. Hargrove," visited Aiea Heights just to meet with their compatriot service-artist.

Throughout the war, these three military cartoonists were far from being alone in their creative pursuits. Even within the Navy Medical Department several professional artists were in uniform. In addition to PhM2c Woodcock, the Navy had PhM2c Coleman Anderson. Anderson, who spent the war as an illustrator at the Naval Medical School in Bethesda producing posters and drawings, was one of Chester Gould's artists-in-residence. Before "aiding in the education and training of Navy and Marine Corps personnel," Anderson was developing Dick Tracy comic strips and drawing such colorful villains as "Flattop," "B.O. Plenty," and "Pruneface." After the war, Anderson returned to the Gould studio where he served as the "background artist" for the Dick Tracy comics until 1957.

Other "in-house" artists included PhM2c Steve Tabone who served as the illustrator-in-residence for the Navy's *Hospital Corps Quarterly* and a mysterious corpsman-artist simply identified as "Penberthy" who drew a weekly comic strip called "Moiphy." Even a Navy physician named Charles Waite (later RADM) penned and published many morale boosting cartoons and illustrations for the war effort; most notable was a "history of naval medicine" that was reminiscent of the famous "Ripley's Believe It or Not" comic strip.

On 20 August 1945, Woodcock published Foxhole's last "hurrah," a retrospective of the calamitous sailor's wartime service. Like his creator, after almost 4 years of service, he was leaving the Navy.

After the war, Woodcock found employment in New York City, penciling and inking many comic books. It was there that Jerry Siegel and Joe Shuster, the creators of "Superman," approached him. The asked if he would join forces to develop a new comic book. Woodcock remembered, "They talked to me about losing their Superman comic and asked me if I was interested in working on a new comic strip, something about a crime-fighting clown. I had to turn them down due to other work." Fortunately, this was a choice Woodcock would not live to forget. The Siegel and Shuster creation that Woodcock turned down was the failed comic book called *Funnyman.**

In the late '40s, Robert Woodcock moved away from comic strips and into the more lucrative field of advertising and commercial art. It was a successful career that took him around the globe. But through it all his short stint in the Navy was not lost even though it may have been forgotten by many. When Robert Woodcock looks back today, he notes that "We serve our time in the military in whatever capacity and with little thought about what if any impact we have had during our enlistment."

After the war, Robert G. Woodcock was commissioned to do documentary artwork for the U.S. Air Force depicting life at Air Force bases around the globe. Many of these illustrations can now be found in the Pentagon, the Smithsonian Institution art collection, and at the National Museum of the United States Air Force at Wright-Patterson Air Force Base, Dayton, OH. Later he was given the honorary rank of "Colonel, USAF" for his work.

His work would take him from Seattle, to Washington, DC, New York, and Los Angeles (where he headed his own studio). In 1974-75 he served as President of the Los Angeles Society of Illustration. Over the years, he served as an instructor at the University of Washington in Seattle, WA, Art Center College in Pasadena, CA, and the Otis/Parsons School of Design in Los Angeles, CA.

After "retiring" in 1982, Woodcock relocated to Prescott, AZ, where he discovered a new interest—Western-themed art. He began painting "the life of the working cowboy in oil, acrylic, and pencil." His more than 180 paintings depicting Western scenes have been featured in *Art of the West* magazine and many galleries and private collections. In 2004, Woodcock retired once again and moved to Roseburg, OR, where he lives with his wife Dorothy.—ABS

Cartoonists George Baker (L) and Marion Hargrove (R) with Robert Woodcock at Aiea Heights.

**Funnyman*, which lasted a mere six issues (January-August 1948), marked Siegel and Shuster's final collaboration.

A Case Study for Ethical Leadership Decision Making

The Corpsman

Shaun Baker, PhD
Elizabeth Holmes, PhD, ABPP
Rose Ciccarelli, MA

You are CAPT Jones in command of a Marine platoon, part of a large three-battalion operation in a compact urban area. Your platoon is one of 40 sweeping the city from east to west. The city is bordered on the west by a wide swift river that runs into an ocean directly south. You are to move from east to west along the line of advance, keeping pace with the other platoons. Moving through a neighborhood, you are searching for and clearing enemy insurgents. Adjacent units north and south of you are doing the same.

Based on recent experience and the mood of the city, planners strongly believe the enemy will flee rather than fight. They cannot run north, being hemmed in by impassible mountains, or escape southward because of the ocean.

The idea is to advance through the city as quickly as possible, pushing the enemy into a kill box—undeveloped land near the river—where air support can come into play, killing or forcing surrender. Either way, valuable results will follow: a significant reduction in the number and morale of the enemy and valuable intelligence extracted from prisoners. Additionally, this operation, if successful, will help build the confidence of the non-combatant populace, something that is vital to the overall counterinsurgency campaign.

Marine and civilian casualties, along with prisoners, are being sent well to the rear, accompanied by corpsmen when necessary. Once casualties are evacuated, corpsmen return to their companies as soon as possible.

The fighting has been much more intense than expected. The enemy is desperate. None surrender. Your platoon has lost all its corpsmen, except one. You have already evacuated several badly injured Marines and some civilians. You expect the intense combat to continue.

You emphasize to your one remaining corpsman, HM1 Smith, that he is to take care of as much in the field as he can, evacuating only in the worst of circumstances.

During a particularly bloody firefight, five of your men break into an apartment located on the third floor of one of the many apartment buildings bordering the street. Intense automatic weapons fire had come from that area, killing one of your men.

They have discovered that insurgents used the room as a torture chamber and prison. There are decayed corpses in the room, and one young boy, no more than 10 years old, is still alive. Unfed, with grievous injuries, he pleads for help. When you and HM1 Smith rush to the room, the sight is shocking. You've seen a lot of things, but never anything quite like this. Smith examines the boy.

You ask Smith if it is possible to evacuate him. He shakes his head, "I'm not sure. These wounds are gangrenous, he's slipping in and out of consciousness, and seems to have internal bleeding. I am certain if he doesn't get surgery soon he will die."

If the boy is evacuated, Smith will have to accompany him. He doesn't need to remind you that he's the only person with medical expertise left in your platoon. With the ongoing fight, if you order Smith to evacuate the child, there will be no medical asset until he returns. And with the continuing firefight your Marines will be more vulnerable without medical presence.

There is no way of knowing how long Smith might be gone. Regardless, that time will be significant. You hate to think it, but what if this boy is already lost? Should you assuage your conscience by attempting the evacuation? Would that act be self-indulgent? Even Smith can't be sure whether the boy has a chance. What can be done for any Marines who might be injured during his absence.

Should you leave the boy and order Smith to stay with the platoon as you fight your way out of the area? That would certainly be consistent with plans and orders. It would create the best chance for the mission's success

and not remove your most valuable medical resource.

You can report the boy's location to a rescue team. Of course, given his condition, this will likely result in his death. He is obviously in agony. A rescue team will have to fight their way in and he doesn't have that kind of time. You are here now. You have Smith. He can get the boy to safety. You could save his life. All you need to do is call in a Humvee. Aren't you supposed to look out for the defenseless, even at risk of your own safety or the safety of men under your command? Isn't that part of the warrior code?

Even though only a minute or two had elapsed since examining the boy, the time seems interminable until you hear Smith's voice cutting through your thoughts, "Orders, Captain?"

You curse under your breath, sigh, look at the young victim, then at the scene beyond the window, and at your awaiting corpsman.

What would you do?

Ethical Leadership Decision Model

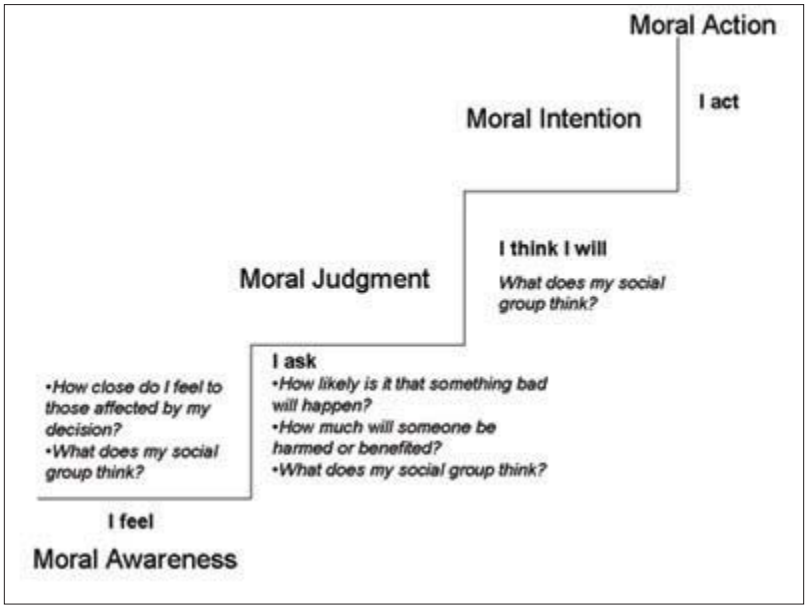
Research has shown that people proceed through a series of stages when processing an ethical decision. The stages move from an initial recognition or awareness of morally salient features of environment—that is, problem situations—to a probing of possible courses of action that would resolve the problem, to an exploration of the consequences of the proposed solutions, and a resultant decision to act or refrain from acting. The research shows that ethical, social, and psychological factors affect the process at each one of these stages. Psychological and social factors can exert influence without our being aware of them. Sometimes these influences lead to good choices, sometimes to ill. The model shown, based on sound theory and validated by Dr. Holmes's research, is one approach in making practical, pragmatic decisions quickly, with conscious and deliberate awareness of these factors. This increases the likelihood of making sound moral choices, even in difficult circumstances.

This four-step approach is based on James Rest's Model (1986), along with Thomas Jones' (1991) idea that moral intensity factors influence each of those components. For example, how much someone is harmed or benefited by the decision-maker's actions may influence the decision, as well as how much the social group agrees that a given action is good or bad. How close the decision-maker feels to the people affected by the decision and the probability that something harmful will occur can also color decision making. By asking questions that probe those moral intensity factors, the decision-maker becomes aware of how they may be affecting decision making.

To make an ethical decision, a person works through the stages in the process, moving from moral awareness to moral action. In the first stage, there is gut-level recognition that the situation is morally charged. Anger, fear, anxiety, concern, and/or empathy are aroused. The decision-maker's gut is answering the question: "Is there something wrong here?" Two moral intensity factors—proximity (how close the decision-maker feels to the people affected) and social consensus (whether a social group perceives a given action as right or wrong)—can influence whether the decision-maker identifies an ethical issue. Becoming reflexively (consciously or "meta-cognitively") aware of these influences can help one correct for oversensitivity or insensitivity in such cases.

Assuming that the decision-maker identifies an ethical issue, he or she begins to weigh various options in the next stage. The aim is to distinguish right from wrong, better from worse, and between competing obligations. The decision-maker is weighing possible actions. Moral intensity factors such as magnitude of consequences (how much someone is harmed or benefited by the decision-maker's action), probability of effect (the likelihood that predicted circumstances and expected level of harm or benefit will occur), and social consensus play roles in this stage of the process.

The next stage builds on the results of the last. In this stage, the person must decide what to do or not do. Sometimes choosing not to act is a valid decision. Deciding what to do also means marshaling the courage to act or not act, sometimes in the face of great opposition. In deciding to act, research shows social consensus plays the biggest role.



Sometimes, people can recognize an ethical dilemma, decide "the right thing to do," resolve to act, and yet do not. The power of other people present is the most common explanation used for failing to act morally. In the last stage, a person carries out his or her decision, in spite of opposition or possible consequences, or chooses not to act.

The Model Applied to the Case Study

The model can be used to work through the decision point presented in the case study. The first step is to decide if this situation contains an ethical problem.

1. Ask yourself if any ethical issues are raised by the case study. This is an application of the moral awareness part of the model. Is anything wrong here? Is a person, community, or ideal at risk? Use the questions below as a way to guide your awareness of moral intensity factors.

• Who is affected by this situation and any decision I may make?

• How close do I feel to those affected by this situation?

• What do my peers think? Would they perceive an ethical problem here?

Below are some of the ethical issues the case study raises:

•The boy may die if not cared for by the corpsman.

• The boy cannot defend himself if you move on and call in follow-on aid.

• If the corpsman accompanies the boy, injured Marines may be at risk, because the corpsman will not be there to care for them in the field.

2. Using the moral judgment step in the model, formulate questions that will help you weigh various options. Here are some samples of moral judgment questions. Some questions help you to see how the moral intensity factors of magnitude of consequences, probability of effect, and social consensus might affect your decision making:

• Is it fair or unfair to leave the boy for follow-on aid? To evacuate him immediately?

• Is it just or unjust to leave the boy? To evacuate him now?

• Is it morally right or wrong to leave the boy for follow-on aid? To evacuate him now?

• Would leaving the boy and relaying his location to follow-on rescuers be acceptable to my family and friends, mentors, or other people I respect? Would it be acceptable to the boy's family, if they are alive? What about evacuating him now? How would these people respond to that action?

• Is leaving the boy, radioing his location and moving on in line with the standards, culture, and traditions of the Marine Corps? How about evacuating him now?

• Does leaving the boy for follow-on rescue violate a promise or code that is important to the Marine Corps? How about evacuating him now?

• What is the extent of harm or benefit that could occur if the boy is left for follow-on rescue as we move on?

• What is the extent of harm or benefit that could occur if the boy is evacuated now?

• How does the magnitude of possible consequences influence my moral judgment?

• How likely are the various harms and benefits from the various options in this situation? How do the probabilities affect my moral judgment?

• What would my peers think about the potential consequences? How would their opinions affect my moral judgment?

3. Using the moral intention step in the model, decide what you will do in this situation. Here are some sample moral intention questions:

• What do I think I should do?

• Do I really intend to act on my decision?

• Do I intend to follow standard procedure or depart from it?

Here are some examples of questions that highlight how the moral intensity/social consensus factor might influence your decision making:

• How would my men likely act if in my place?

• How do they expect me to act?

• How does my perception of my Marines' intentions, expectations, or wishes influence my intention?

4. Using the moral action step in the model, ask yourself whether you will follow through with your decision. Here are some sample moral action questions:

• Would I really follow through on my intention?

• What might prevent me from acting on my intention?

• What might aid me in following through on my intention?

Here are further examples of how the moral intensity factor of social consensus might affect your moral action:

• Would other company commanders act on their decisions if in a similar situation?

• How do their potential actions influence my behavior?

Learning to apply the ethical decision making model to case studies like "The Corpsman" assists you in developing the moral "muscle memory" that will be required in high stress situations. Difficult ethical decision making becomes easier when it is built on the foundation of ongoing practice. Walking the steps from moral awareness to moral action is an indispensible skill of an ethical leader.

Dr. Baker is Assistant Director, Ms. Ciccarelli is Staff Writer, and Dr. Holmes is Director of Assessment at Stockdale Center for Ethical Leadership, U.S. Naval Academy, Annapolis, MD.

BUILDING A SEA-BASED MEDICAL SUPPORT SYSTEM

PART VI: Is the Hospital Ship Heading Toward Obsolescence?

CAPT Arthur M. Smith, MC, USNR (Ret.)

The modern naval warfare environment has grown ever more dangerous and unpredictable. Unbridled offensive weaponry now threatens any noncombatant ship that strays within target range. In a setting of air, sea, and ground-launched missile warfare, compounded by the evolving ubiquity of sophisticated mines, electronic sensors, diesel submarines, and other weapons available in the international arms market, a tactical environment of unparalleled complexity awaits future sea-based forces operating in littoral waters. These same complexities may impede the expedited evacuation of casualties to medical treatment vessels, including traditional hospital ships, resulting in meaningful delay of timely medical management of the wounded.

Likewise, the threat of international terrorism may further impact upon the safety of these unprotected vessels in littoral waters. In the current evolving era, of time limited long distance deployments of personnel and equipment over vast regions of ocean; will hospital ships as we have known them—primarily relics of a strategy for evacuating the sick and wounded from Europe during the Cold War—be capable of playing a meaningful role?

Historical Background

Emanating from international conferences held both in Geneva during the 19th century and in The Hague in the early 20th century, the international community endowed hospital ships with defined protections. They promulgated the conditions under which hospital ships were entitled to immunity from attack, and under which they warranted respect in time of war. To facilitate hospital ship identification at sea, all hospital ships were required to be adorned with red crosses painted on their sides—fore, aft, and amidships—while flying their national flag as well as the Red Cross flag. To ensure that they were distinguishable at night, the hulls were further mandated to be brilliantly illuminated with long rows of red and green lights along the sides to protect them from attack. They were also required to steam independent of combatant vessels without weapons or the use of encrypted communications. Over the years other means of identification have also been considered, analyzing whether location and identity information might be concurrently conveyed to the belligerents by innovative electronic and underwater methods.

Have historic means for vessel identification consistently provided a mantle of protection? Internationally recognized principles governing the protected neutrality of ships have always been contingent upon reciprocal acceptability by the opposing parties. An anecdote demonstrating the importance of reciprocal "credibility" among belligerents is instructive. During World War II it had been reported that 5,000 U.S. prisoners of war perished aboard Japanese "hell ships" at the hands of U.S. submarines. Would specific, pre-announced identification of the track of the Japanese prison transport *Arisan Maru,* which held 1,800 U.S. prisoners of war, have convinced the commander of the submarine USS *Snook* (SS-279) not to launch the torpedo that destroyed it, killing all but five? Would the prison ship *Shinyo Maru,* lost with all but 82 of the 750 U.S. prisoners of war aboard, have likewise been saved from the torpedoes of the submarine USS *Paddle* (SS-263)? Unfortunately, such track information might well have been ignored, given the prevailing "perception" that the Japanese had a prior record of abusing formerly agreed upon identification methods.

The Impact of Ignored Identification

History demonstrates that some parties may be indifferent to the Western etiquette of war. In 1917, in disregard of international law, the Central Powers of World War I declared that hospital ships, no matter how prominently marked in compliance with the Geneva and Hague Convention accords, were no longer protected as neutral vessels. Such ships were denied immunity from attack in the English Channel, parts of the North Sea, and

PHOTOS COURTESY OF AUTHOR

MV *Limburg* under attack

the Mediterranean, even if attackers knew their identities. Between 1917 and 1918 alone, eight hospital ships were torpedoed. Overall, the British lost 15 hospital ships, most from mines and torpedo attacks. Similarly, during World War II, Germany, and later Italy, showed complete disregard for the Hague Convention accords. By the middle of 1941, although all Allied hospital ships were clearly marked, no fewer than 13 had been sunk.

In the Pacific during April 1945, after the invasion of Okinawa began, enemy planes attacked three hospital ships. Although USS *Relief* (AH-1) and USS *Solace* (AH-5) were attacked, no damage was inflicted. The only ship to suffer major damage and casualties was USS *Comfort* (AH-6). On 28 April, while steaming away from the scene of combat, fully lighted in accordance with Geneva Convention protections, *Comfort* was hit amidships by a kamikaze, resulting in 22 killed, 11 wounded, and 19 missing. (Ironically, other "gray hull" casualty evacuation ships lying in close support just off the landing beaches and within the protected ring of picket ships and transport area defenses, suffered no significant damage.) Nevertheless, hospital ships continued to perform regular shuttle trips to hospitals in the Marianas.

During UN ground operations in Korea in the early 1950s, violations of neutrality continued. Attacks upon medical personnel, vehicles, and tents became the rule, rather than the exception. The aid station was the first target of North Korean artillery; North Korean riflemen used the Red Cross on regimental ambulances as a convenient "bull's-eye." An historical review of noncompliance with traditional symbols of medical identification in Korea reveals an epic photograph of a soldier defensively smearing mud over the Red Cross on the side of his ambulance. Likewise, the historic record relates the saga of a Red Cross marked hospital train that was attacked while leaving Taegu at night for Pusan, and then hit again as it emerged from a tunnel. As a result, hospital trains were required to run only during daylight hours; emergency night runs were guarded by military policemen, who rode on sandbagged flatcars.

The Falklands: The Unique True Test of Protected Neutrality for Medical Ships

The Falklands campaign afforded an opportunity to analyze the benefits of protected neutrality established between adversaries through concurrence with international agreements. In 1982 the United Kingdom's Royal Navy secured the rapid modification of the commercial P&O cruise ship SS *Uganda* into a capable hospital ship. It sailed to the Falklands operating area unescorted by combatants, with sustained appropriate identification in accordance with international conventions. At Britain's suggestion, although with no special written agreement, the opposing parties established a neutral zone on the high seas, to the north of the islands, known as the "Red Cross Box." *Uganda* subsequently operated within this zone, 20 nautical miles on a side, along with Argentine casualty assistance vessels, and periodically implemented casualty transfers among them. *Uganda* was assisted by three Royal Navy ocean survey ships converted to protected ambulance vessels. These ships carried 593 stabilized casualties to a neutral aero-medical transfer point in Montevideo, Uruguay, 420 miles away. This cleared room onboard the hospital ship for new wounded.

Immediately prior to the British Falklands invasion, the Royal Navy also requisitioned the luxury liner SS *Canberra,* which was rapidly converted into a troop carrier equipped with a major surgical facility. Plans called for it to receive casualties after unloading, although *Canberra* did not qualify for neutrality by virtue of having traveled in company with combatant-ship escorts, and transported both troops and combat equipment to the theater. It was felt, however, that the absence of protected neutrality might also be advantageous, since troops could be successfully treated on board and subsequently returned to the field directly, something prohibited from occurring aboard "protected" hospital ships. Unfortunately, as a result of fierce Argentine aerial attacks upon the fleet supporting the landing force, it was necessary to remove the unarmed "gray hull" *Canberra* from the San Carlos operational area.

The Impact of Missile Warfare

In the setting of missile warfare, the vulnerability of unarmed vessels to the errant course of misdirected projectiles was illustrated during the Falklands conflict by the fate of the transport MV *Atlantic Conveyor,* which suffered attack by a deflected missile. On 25 May 1982, two Super Etendards of the Argentine Air Force appeared at a point 70 miles east of the Falkland Islands. The British were still more than 30 miles to the north when the frigate HMS *Ambuscade* detected an air attack and immediately alerted the fleet. While the fate of one Exocet missile was never determined, several of the crew on *Ambuscade*'s bridge saw the smoke trail of a second Exocet boring in, the red glow of its exhaust clearly visible. The ship opened fire with its 4.5-inch gun, antiaircraft guns, and machine guns.

Above all, every British warship in the battle group fired chaff radar decoys. A Lynx helicopter is also believed to have been operating an active decoy. Unfortunately, the 13,000-ton container ship *Atlantic Conveyor,* perhaps 2 miles to starboard of *Ambuscade,* possessed no defensive chaff. The missile veered sharply in midair away from the warships (including the carrier HMS *Invincible*) and struck *Conveyor* below the superstructure on the port side. A huge fire quickly took hold, eventually sinking the ship.

The harsh and unpredictable nature of contemporary missile-based warfare is further exemplified by the mistaken attack on an Iranian passenger jet in 1988 by the Aegis equipped cruiser USS *Vincennes* (CG-49). The mishap occurred despite the functioning sophisticated electronic warfare systems operating aboard *Vincennes*. That tragedy brought into question the safety, effectiveness, and survivability of any unarmed craft—aircraft or ship—much less those dedicated exclusively to the care of the combat wounded. Ultimately, it is doubtful that any sensor will be capable of discriminating between an ostensibly Geneva-protected and non-protected vehicles, other than the human eye, and only then if within visual range. In reality, merely detecting a radar or transponder signal requires less technological sophistication than does interpreting it. Thus, a less technologically advanced adversary who is determined to win a conflict, can use a raw signal from a craft to guide a missile without ever appreciating or acknowledging the target's noncombatant role, such as that of a hospital ship.

Alternatives to Protected Hospital Ships as We Now Know Them

Just as casualty care and evacuation requirements emanate from the province of combatant commanders who ultimately define scenario-specific needs, the most appropriate remedy for protection of medical assets in each operational setting is likewise their responsibility. During future military contingencies, an operational commander may determine that medical evacuation and treatment vessels, such as traditional hospital ships, can no longer benefit from the accustomed mantle of "privileged immunity" provided by both Hague and Geneva Conventions. For purposes of protection from directed missiles, such as the C-802 Iranian-made variant of a Chinese Silkworm cruise missile recently directed at Israeli ships off the Lebanon coast by Hezbollah in July 2006, or misdirected missiles such as the Argentine Exocet which electronically deviated from its course and struck MV *Atlantic Conveyor* at the Falklands, casualty treatment ships previously marked with the Red Cross may be obligated to convert to unmarked anonymity, and likewise carry antimissile defenses and utilize encrypted communications. Their only remaining option, if remaining as marked "protected ships," namely geographic separation from combat operations, may well be counterproductive to the principal mission of forward casualty support. Indeed, because of missile threats during the 1991 Gulf War, the two U.S. hospital ships were kept too far from the combat scene to serve as critical resources for acute casualty care. The protracted distances conflicted with the flying time capability, as well as the carrying capacity of medical evacuation helicopters, thereby limiting access to these vessels by ground-based casualties.

By contrast, the Royal Navy concurrently initiated the innovative construction of an internal airtight citadel housing a casualty-receiving hospital in a portion of its "gray-hull" helicopter-training ship RFA *Argus,* recognizing that this arrangement best suited the needs of the combatant command. As such, it should not be expected that dedicated "protected" hospital ships, as we have known them in the past, will be readily available to every task force entering dangerous littoral waters.

Speed Limitations of Hospital Ships

In consideration of future needs for rapid surge delivery of forces to threatened littoral operations around the world, and the current emphasis upon decreased strategic closure times, Navy assets will be under tremendous pressure to improve high speed logistical lift, and match the greater than 30- to 33-knot speed of current surge sealift ships. The previously demonstrated protracted time lines for transit of current hospital ships may therefore render them incompatible with projected concepts of future sea-based war fighting. Indeed, during tsunami relief operations in the littorals of the Indian Ocean and Bay of Bengal, following official notification of activation of USNS *Mercy* (T-AH 19) from the Commander in Chief, Pacific Fleet on 1 January 2005, the ship did not arrive off the coast of Bandeh Aceh, Indonesia and commence relief operations until 6 February. Likewise, during prior support of Operation Desert Shield amidst conflict in the Middle East, while *Mercy* had been activated on 9 August 1990 it did not arrive in the Arabian Gulf until 15 September 1990.

Political Limitations of Hospital Ships

Because of political and military considerations in 2003 during Operation Iraqi Freedom, the military medical system was constrained by an inability to evacuate Iraqi casualties (both civilians and prisoners of war) to neighboring countries. Likewise, U.S. amphibious task force ships with concurrent military obligations were prohibited from accepting and transporting human cargo. Accordingly, the principal activity aboard hospital ship USNS *Comfort* (T-AH 20) was directed toward the treatment of prisoners of war and displaced Iraqi nationals, while strategic airlift was concurrently provided for coalition wounded to Kuwait and Germany.

Indeed, tactical analysis in the setting of littoral warfare suggests that

medical support at this level might be best implemented using predominantly aviation-based evacuation assets for "friendly" casualty evacuation. Furthermore, to satisfy the medical requirements in any littoral conflict, an equally important caveat is the existence of safe and effective strategic medical evacuation plans directed to medical facilities outside the zone of conflict. Recent experiences in Afghanistan and Iraq, as well as the revelation of uncertain security at terrorist-prone littoral anchorages and berthing facilities, likewise suggest that evacuation by air may well be the preferred mode of casualty transport. These considerations may render obsolete the entire discussion of protected immunity for hospital ships.

Terrorism and Port Security

In the setting of international terrorism, the sanctity of Geneva Convention protection cannot be taken for granted. Historically, attacks against maritime targets have been infrequent forms of terrorism. Although the hijacking of *Achille Lauro* in 1985 and the bombings of both USS *Cole* (DDG-67) in 2000 and MV *Limburg* in 2001 are notable exceptions, few terrorist incidents have taken place at sea. The general vulnerability of the ocean environment, however, has become more apparent, attributed in part to lax security at many world ports as well as ineffective coastal surveillance by littoral states that are now confronting serious campaigns of political violence and latent extremist transnational challenges. This is especially true in Indonesia, the Philippines, Colombia, Bangladesh, India, Pakistan, and the countries around the Horn of Africa.

Likewise, al Qaida has maintained an interest in maritime terrorism. The insurgents have shown that they can and will exploit the sea for operational attack using boats, small vessels, or converted and seized vessels, Radical Islamists have demonstrated themselves capable of mounting irregular, surprise attacks on single, unwary combatants and commercial vessels, both at sea and in port. Although a planned 1999 attack on USS *The Sullivans* (DDG-68) failed, the 2000 attack on the USS *Cole,* one of the most advanced U.S. naval ships, possessing both Phalanx missiles and defensive machine guns, succeeded, leaving 17 sailors dead. The ship almost sank.

Damage to USS *Cole* after terriorist attack.

It was discovered that the architect of the attacks on both *Cole* and MV *Limburg* also dispatched maritime terror squads to Morocco to target Navy ships passing through the Straits of Gibraltar. Similar plots in Southeast Asia were evidenced by charts in the possession of suspected terrorists marked with the location of Sembawang Wharf and Changi Port, Singapore, as well as the crowded port of Surabaya in eastern Java, Indonesia. The 120 annual port visits by Navy vessels to the region are expected to increase, following the construction of an aircraft carrier docking facility at Singapore's Changi Naval Base.

How, then, will casualties be supported in the future? Will commercially chartered cruise ships be available, such as the P&O cruise ship SS *Uganda* utilized during the Falklands campaign as a hospital ship, which already contained hotel, laundry, and other facilities required by a hospital? Perhaps there will only be logistics-support ships available, such as vessels of the Military Sealift Command. Even if supplemented with medical modules and appropriately staffed with the capability for in-transit casualty treatment, none of these would be eligible for protected neutrality if first utilized for transport of war fighting materiel.

It may be that no specific form of a current hospital ship, or converted logistics ship, will be sufficiently secure for use by combatant commanders. There is no guarantee, even if a new form of surface medical evacuation vehicle is developed and outfitted with sophisticated cryptographic communications and modern defensive armaments such as chaff, the Phalanx anti-missile system, and electronic countermeasures, that a white-painted hull with large red stripes will provide effective defense. (Clearly, such armament capabilities did not deter the disaster that befell USS *Stark* (FFG-31) when attacked in 1987 by Iraqi air-launched Exocet missiles.)

Perhaps as a result of uncertainties regarding the safety of traditional ships' berthing venues in the new environment of worldwide terror, and the ubiquitous presence of modern missile weaponry available on the international arms market, aeromedical evacuation may surpass any practical approach to primary medical evacuation by surface ships. As such, the viability of the concept of the "protected" hospital ship, may be seriously questioned, and it may yet be relegated to that of an historic relic.

CAPT Smith is Adjunct Professor of Military and Emergency Medicine, and Adjunct Professor of Surgery at the Uniformed Services University of the Health Sciences, Bethesda, MD, and Professor of Surgery (Urology) at the Medical College of Georgia.

In Memoriam

CAPT Bernadette Alice McKay, NC, USNR, died on 11 October. She was 80. McKay was a native of New York, NY.

CAPT McKay received her basic nursing education at St. Vincent's Hospital School of Nursing in New York. She enlisted as an ensign in the Navy Nurse Corps Reserve on 11 March 1952. In 1957, she transferred to the regular Navy.

Over the years she served as an operating room nurse at Naval Hospitals in Portsmouth, VA; Oakland, CA; St. Albans, NY; as well as the Navy Medical Unit at Tripler Army Hospital at Oahu, HI. In November 1964, CAPT McKay joined a Navy surgical team of a provincial hospital at Rach Gia, Vietnam where she served as a nurse advisor on detached duty to the Agency for International Development, Department of State.

Following her return from Vietnam, CAPT McKay served as operating room supervisor and assistant chief of the nursing service at Naval Hospital Philadelphia, PA, and later the chief of nursing service at Lemoore, CA. In 1975, she became the director for administrative services at the Naval Submarine Medical Center in New London, CT. She held the distinction of being first nurse in the history of the Navy Medical Department to serve in this executive position. She retired from the Navy in 1986.

CAPT McKay held degrees from the University of Minnesota (BS, Nursing Administration, 1962) and Catholic University (MA, 1968).

CAPT McKay's awards included the Navy Commendation Medal; Combat Action Ribbon; Armed Forces Honor Medal; Vietnamese Service Medal; Vietnamese Campaign Medal; Civil Actions Medal; Meritorious Unit Commendation Ribbon; and the National Defense Service Medal with bronze star.

CAPT Bernadette McKay will be laid to rest at Arlington National Cemetery on 22 January 2009.

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Surgeon General's Reading List 2009

The following is the Surgeon General's list of book titles recommended for all members of the Medical Department. This catalog of historical and literary works are, in a sense, ports of call on a quest for knowledge and wisdom. Enjoy them as you set sail on a voyage of discovery.

Autobiography, Biography & Memoir

The Civil War Sketchbook of Charles Ellery Stedman, Surgeon, United States Navy
~ Jim Dan Hill

The Coldest War: A Memoir of Korea
~ James Brady

Combat Surgeon: Up Front with the 27th Marines
~ James S. Vedder

Douglass and Lincoln: How a Revolutionary Black Leader and a Reluctant Liberator Struggled to End Slavery and Save the Union
~ Stephen Kendrick

Fiddlers and Whores: The Candid Memoirs of a Surgeon in Nelson's Fleet
~ James Lowry

Franklin Delano Roosevelt: Champion of Freedom
~ Conrad Black

Lincoln and Chief Justice Taney: Lincoln and Taney
~ James F. Simon

The Life Story of Presley Marion Rixey: Surgeon General, U.S. Navy, 1902-1910: Biography and Autobiography
~ William C. Braisted, William Hemphill Bell and Presley M. Rixey

Master of Sea Power
~ Thomas Buell

Naval Surgeon: Life and Death at Sea in the Age of Sail
~ J. Worth Estes

Navy Surgeon
~ Herbert Lamont Pugh

Nimitz
~ E.B. Potter

On Watch: A Memoir
~ Elmo Zumwalt

The Presidents' Doctor: An Insider's View of Three First Families
~ Milton F. Heller, Jr.

The Quiet Warrior
~ Thomas Buell

Team of Rivals: The Political Genius of Abraham Lincoln
~ Doris Kearns Goodwin

Theodore Rex
~ Edmund Morris

Truman
~ David McCullough

Two Years Before the Mast: A Personal Narrative of Life at Sea
~ Richard Henry Dana, Jr.

Winston Spencer Churchill: The Last Lion
~ William Manchester

Yankee Surgeon: the Life and Times of Usher Parsons, 1788-1868
~ Seebert J. Goldowsky

Literary Classics

The Asian Saga:
•Gai-Jin
•King Rat
•Noble House: A Novel of Contemporary Hong Kong
•Shogun Whirlwind
~ James Clavell

Catch-22
~ Joseph Heller

The Caine Mutiny
~ Herman Wouk

The Century of the Surgeon
~ Jurgen Thorwald

The Cruel Sea
~ Nicholas Monsarrat

Fields of Fire
~ James Webb

M*A*S*H: A Story about Three Army Doctors
~ Richard Hooker

Once an Eagle
~ Anton Myrer

The House of God: The Classic Novel of Life and Death in an American Hospital
~ Samuel Shem

Winds of War and Remembrance
~ Herman Wouk

The United States Navy
~ Edward L. Beach

Medical & Military History Medical

Battle Station Sick Bay
~ Jan K. Herman

Blood, Pure and Eloquent: A Story of Discovery, of People, and of Ideas
~ Maxwell Wintrobe (editor)

The Care of Strangers: The Rise of America's Hospital System
~ Charles E. Rosenberg
Training for Excellence: A History of Medical Education and Training in the United States Navy
~David P. Gray
Fighting for Life: American Military Medicine in World War II
~ Albert Cowdery
Frozen in Memory: U.S. Navy Medicine in the Korean War
~ Jan K. Herman
Goldberger's War: The Life and Work of a Public Health Crusader
~ Alan M. Kraut
The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present
~ Roy Porter
A History of Medicine in the Early U.S. Navy
~ Harold Langley
Many Specialties, One Corps: A History of the U.S. Navy Medical Service Corps
~ David P. Gray
Medics at War: Military Medicine from Colonial Times to the 21st Century
~ John W. Greenwood and F. Clifton Berry, Jr.
Medicine Under Sail
~ Zachary Friedenberg
PPG 2266: A Surgeon's War
~Nikolai Mikhailovich Amosov
The Social Transformation of American Medicine
~ Paul Starr
Vaccinated: One Man's Quest to Defeat the World's Deadliest Diseases
~ Paul A. Offit
The White House Physician: A History from Washington to George W. Bush
~ Ludwig Deppisch
At Dawn We Slept
~ Gordon Prange.
Band of Brothers
~ Stephen Ambrose.
Blind Man's Bluff: The Untold Story of American Submarine Espionage
~ Sherry Sontag and Christopher Drew
Breakout
~ Martin Russ
The Bonus Army
~ Paul Dickson and Thomas B. Allen
A Bright Shining Lie: John Paul Vann and America in Viet Nam
~ Neil Sheehan
Citizen Soldiers
~ Stephen Ambrose.
D-Day
~ Stephen Ambrose.
Dreadnought
~ Robert Massie
Flags of Our Fathers
~ James Bradley and Ron Powers
Flyboys
~ James Bradley
The Greatest Generation
~ Tom Brokaw
The Guns of August
~ Barbara Tuchman
The Last Mission
~ Jim Smith and Malcolm McConnell
The Last Stand of the Tin Can Sailors
~ James Hornfischer
Miracle at Midway
~ Gordon Prange.
The Path Between the Seas: The Creation of the Panama Canal 1870-1914
~ David McCullough
Run Silent, Run Deep
~ Edward L. Beach
Sea of Glory: A Naval History of the American Revolution
~ Nathan Miller
Sea of Thunder: Four Commanders and the Last Great Naval Campaign—1941-45
~ Evan Thomas
The Seven Pillars of Wisdom
~ T.E. Lawrence (aka "Lawrence of Arabia.")
Ship of Ghosts: the Story of the USS* Houston*, FDR's Legendary Lost Cruiser, and the Epic Saga of the Survivors
~ James Hornfischer
Six Frigates: the Epic History of the Founding of the U.S. Navy
~ Ian Toll
Thunder Below!: The USS* *Barb* *Revolutionizes Submarine Warfare in World War II
~ Eugene B. Fluckey
The Two Ocean War
~ Samuel Eliot Morison
The Tragedy at Honda: The Greatest Peacetime Tragedy in the U.S. Navy; the Heroism of the Crews, the Inquiry and the Resulting Court Martial
~ Charles A. Lockwood, Hans Christian Adamson, and Chester Nimitz.

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Navy Medicine 1938

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